Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02501

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Magdalene M. Fowler
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 3:05 PM

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-22-6071
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/7/1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6529 Hilltop Avenue
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Green
18. Mother's Name (First, Middle, Maiden Surname): Ann Mueller

19a. Informant's Name/Relationship (Type, Print): Richard Fowler/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1916 Twin Lakes Drive, Jarrettsville, MD. 21084

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | Date: 2/1/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): e. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D43725
29d. Date signed (Month, Day, Year): 01/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001
32. Registrar's Signature: ▶ [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

January 29, 2001 3:10 p.m.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Magdalene Fowler

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02502

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: SAMUEL K. GROVE
2. Dete of Deeth: Month JANUARY Dey 19 Yeer 2001
3. Time of Death: 8:20 PM
4e. Fecility Neme *(If not institution, give street end number)*: Beverly Health Care
4b. City, Town, or Location of Deeth: Hagerstown
4c. County of Deeth: Washington

Funeral Director

5. Social Security Number: 214-09-3539
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. lest birthdey)*: 88 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Oct 21, 1912
9. Birthpiece *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 750 Dual Highway
10f. Zip Code: 21740
10g. Citizen of Whet Country?: USA
11. Meritel Stetus: 1 [ ] Never Merried 2 [ ] Merried 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: WWII
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* white
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 — College (1-4or 5+): 0
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: salesperson
16b. Kind of Business/Industry: auto parts
17. Fether's Neme *(First, Middle, Last)*: Milford Charlton
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Beulah Catherine Grove
19e. Informent's Neme/Reletionship *(Type, Print)*: Barbara Jackson/grandaughter
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 700 Grandin Avenue Rockville, MD 20850
20e. Method of Disposition: 1 [ ] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [X] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*
Dete
20c. Location - City or Town, State
21. Signeture of Funerel Service Licensee: Ronald S. Wade, Director — Ronald S. Wade
22. Neme end Address of Fecility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. METASTATIC PROSTATE CARCINOMA — 6 Months

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Wes case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of exemineticn end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: Maryen g Mayo
29c. License number: D28365
29d. Dete signed *(Month, Dey, Yeer)*: 1-21-01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MARIAN J. SHAFF 368 Mill Street-Hagerstown MD 21740.

State Registrar

31. Dete filed *(Month, Day, Yeer)*: FEB 01 2001
32. Registrer's Signeture: Geneva B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02503

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EVELYN GOTTSCHALK

2. Date of Death (Month, Day, Year): January 29, 2001

3. Time of Death: 2030

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Belair

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-12-7639

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 6, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Belair

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1512 Honeysuckle Drive

10f. Zip Code: 21014

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Edward Milton Harchenhorn

18. Mother's Name (First, Middle, Maiden Surname): Agnes Rose Morris

19a. Informant's Name/Relationship (Type, Print): Faith Knott/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1512 Honeysuckle Drive Belair, MD 21014

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NON SMALL CELL LUNG CANCER — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

GOTTSCHALK, EVELYN

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John P. Edwards MD

29c. License number: D31775

29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN P. EDWARDS 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Steven G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

01-0485-005
B.K.S

AMENDED ITEMS# 23& 27 per ME G792 022101 SS
ANTHONY GUCKERT
AMENDED ITEM# 6 per fh G792 021601 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02504

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony John Guckert
2. Date of Death (Month, Day, Year): JAN. 29, 2001
3. Time of Death: 12:00 PM
4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER
4b. City, Town, or Location of Death: RANDALLSTOWN
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 214-59-0635
6. Sex: 1☐ M 2☐ F — X
7. Age (In yrs. last birthday): 4 months Yrs. — If Under 1 Year: Months 4, Days 9; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Sept. 20, 2000
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Sparks
10d. Inside City Limits: 1☐ Yes 2☐ No — X
10e. Street and Number: 924 Lower Glencoe Rd.
10f. Zip Code: 21152
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No — X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No — X — Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4or 5+): n/a
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): n/a
16b. Kind of Business/Industry: n/a
17. Father's Name (First, Middle, Last): Anthony Guckert
18. Mother's Name (First, Middle, Maiden Surname): Anna Sakowsky
19a. Informant's Name/Relationship (Type, Print): Anthony Guckert/father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 924 Lower Glencoe Rd., Sparks, MD 21152
20a. Method of Disposition: 1☐ Burial 2☒ Cremation — X — 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto. Wash. Crematory
Date: 2/1/01
20c. Location - City or Town, State: Laurel, MD
21. Signature of Funeral Service Licensee: ▶Michael J. Flagle
22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. SUDDEN INFANT DEATH SYNDROME
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No — X — 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes — X — 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes — X — 2☐ No

25. Was case referred to medical examiner? 1☒ Yes — X — 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient — X — 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural — X — 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. — X
29b. Signature and title of certifier: ▶J. Pestaner, M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: ▶Helena G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02505

Amended Item #1 per PHYG792 2/1/2001 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Gilliland — GILLILAND, CHARLES
2. Date of Death (Month, Day, Year): JANUARY 14, 2001
3. Time of Death: 854 PM
4a. Facility Name (If not institution, give street and number): Stella Maris at Mercy
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 300-30-1628
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 64 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 29, 1936
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1501 Spruce Street
10f. Zip Code: 21226
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No unk — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk
17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): unk
19a. Informant's Name/Relationship (Type, Print): Stella Maris at Mercy
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 301 St. Paul Street Baltimore, MD 21201
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gangrene
Due to (or as a consequence of):
b. Metastatic Recto Sigmoid Colon Cancer.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): STELLA MARIS AT MERCY
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Hospice
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D40854
29d. Date signed (Month, Day, Year): JANUARY 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID RISEBERG 301 St Paul Pl Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02506

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN GORHAM

2. Date of Death: Month JAN Day 28 Year 2001

3. Time of Death: 12:20 PM

4a. Facility Name (If not institution, give street and number): BON SECOURS HOSPITAL 2000 W. BALT.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-50-5459

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 22, 1949

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 6514 FAIRMOUNT AVE

10f. Zip Code: 21215

10g. Citizen of What Country: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COUSELOR

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): THAD GOREHAM

18. Mother's Neme (First, Middle, Maiden Surneme): VIRGINIA MORAN

19a. Informant's Name/Relationship (Type, Print): BARBARA WALTERS, FRIEND

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 722 ALLENDALE RD, BALTO. MD 21216

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): METRO CREMATORY

Date: 2-1-01

20c. Location - City or Town, Stete: BALTIMORE

21. Signature of Funeral Service Licensee: Michael Zeglier

22. Name and Address of Facility: HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. LUNG CANCER — 1YR

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b.

Due to (or as e consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward L. Schaefer M.D.

29c. License number: D18459

29d. Date signed (Month, Day, Year): Jan 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E.W. SCHAEFER M.D. BON SECOURS HOSP.

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02507

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Frances Hogarth

2. Dete of Deeth — Month: January; Dey: 31; Year: 2001

3. Time of Death: 8:15 AM

4a. Fecility Neme (If not institution, give street and number): Genesis Elder Care

4b. City, Town, or Location of Deeth: Randallstown

4c. County of Deeth: Baltimore

Funeral Director

5. Sociel Security Number: 219-18-6665

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 86 Yrs.

If Under 1 Yeer — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth (Month, Dey, Yeer): 7/16/1914

9. Birthplece (Stete or Foreign Country):

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1633 Poles Rd.

10f. Zip Code: 21221

10g. Citizen of What Country: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Nurses Aid

16b. Kind of Business/Industry: Hospital

17. Father's Neme (First, Middle, Last): Larner Pearl James

18. Mother's Neme (First, Middle, Meiden Surneme): Nora Farrell

19e. Informent's Neme/Reletionship (Type, Print): Mary Rinaldi (Daughter)

19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 910 Frog Mortar Rd. Baltimore, Md. 21220

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Green Mount Crematory

Dete: 2/1/2001

20c. Location - City or Town, Stete: Baltimore, Md.

21. Signeture of Funerel Service licensee: John W. Burkowske MO1091

22. Neme end Address of Fecility: Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in death): e. PNEUMONIA

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last:

b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CRITICAL AORTIC STENOSIS, DEMENTIA, HYPERTENSION, ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evelleble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one) — Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier:

29c. License number: D52360

29d. Date signed (Month, Dey, Yeer): 1/31/01

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): KUBIN SANDY, MD 18338 GREENE TREE RD. SUITE 300 PIKESVILLE 21208

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 0 1 2001

32. Registrar's Signeture: D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02508

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY ELIZABETH HANLEY

2. Date of Death Month / Day / Year: JAN. 31, 2001

3. Time of Death: 6:55 A.M.

4a. Facility Name *(If not institution, give street and number)*: 604 CENTRAL AVENUE

4b. City, Town, or Location of Death: TOWSON

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-40-6194

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 6/18/09

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: TOWSON

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 604 CENTRAL AVENUE

10f. Zip Code: 21204

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 2 YEARS; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SECRETARY

16b. Kind of Business/Industry: LAW ENFORCEMENT

17. Father's Name *(First, Middle, Last)*: RICHARD HANLEY

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY PADIAN

19a. Informant's Name/Relationship *(Type, Print)*: KATHLEEN STEEN NIECE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18912 CALDER AVE. PARKTON, MD 21120

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. MARIA CEMETERY

Date: 2/2/01

20c. Location - City or Town, State: TOWSON, MD

21. Signature of Funeral Service Licensee: ▶ M. Neal Coleman

22. Name and Address of Facility: THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Stroke, ischemic — 4 days

Due to (or as a consequence of): b. HYPERTENSION — 15 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Eugene Obah M.D.

29c. License number: D44018

29d. Date signed *(Month, Day, Year)*: 1/31/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Eugene Obah 6565 N. Charles Street Balto. MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: ▶ B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEM #10c per inf G792 020101 SS

Reg. No. 2001 02509

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Miriam C. Hartzell

2. Date of Death: Month JAN Day 26 Year 2001

3. Time of Death: 3:53PM

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 210-26-9093

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 24, 1932

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: ~~Baltimore~~ Linthicum Hgts

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 520 Shipley Road

10f. Zip Code: 21090

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Hospital

17. Father's Name (First, Middle, Last): George M. Coble

18. Mother's Name (First, Middle, Maiden Surname): Louella Barnhart

19a. Informant's Name/Relationship (Type, Print): Kenneth E. Hartzell Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 520 Shipley Road Linthicum, Maryland 21090

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Center, LLC

Date: Jan. 29, 2001

20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Singleton Funeral Home, P.A. 1 Second Avenue, S.W. Glen Burnie, Maryland 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pulmonary Embolus — 7 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert M Yacynych

29c. License number: D0052022

29d. Date signed (Month, Day, Year): Jan 27 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert M. Yacynych Harbor Hospital Center 3001 S. Hanover St Balto MD

State Registrar

31. Date filed (Month, Day, Year): FEB 0 1 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02510

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ARLENE HAMILTON
2. Date of Death Month Day Year: JANUARY 29,01
3. Time of Death: 8:00AM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-56-7200
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR.13,1950
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6 HICKORY RIDGE COURT
10f. Zip Code: 21228
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COMPUTER PROGRAMMER
16b. Kind of Business/Industry: COMPUTER

17. Father's Name (First, Middle, Last): HERBERT KAGEN
18. Mother's Name (First, Middle, Maiden Surname): FANNIE HERSCHLAG

19a. Informant's Name/Relationship (Type, Print): DAVID HAMILTON / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 HICKORY RIDGE COURT - CATONSVILLE, MD 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MIKRO KODESH BETH ISRAEL
Date: 1/31/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

24a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K.S. RAO. M.D
29c. License number: 043462
29d. Date signed (Month, Day, Year): JANUARY 29,01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): K.S. RAO. M.D. NORTHWEST HOSPITAL SENTER, RANDALLSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Jennifer B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02511

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roland H. Herbert

2. Date of Death (Month, Day, Year): January 28, 2001

3. Time of Death: 12:15 PM

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-03-0074

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 29, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 3508 Glenwood Road

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Service Writer

16b. Kind of Business/Industry: Car Dealer

17. Father's Name (First, Middle, Last): William Edwin Herbert

18. Mother's Name (First, Middle, Maiden Surname): Katie Macher

19a. Informant's Name/Relationship (Type, Print): Ann M. Langkam/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3508 Glenwood Road Baltimore, Maryland 21220

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garden of Faith Cemetery

Date: 2/1/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Carl A. Gyl

22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest — 12 hours

Due to (or as a consequence of):

b. Ventricular Arrythmia — 12 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Pneumonia — 5 days

Due to (or as a consequence of):

d. CHF, CAD — 10 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CRF, HTN, CVA

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Chun Hong MD. Ph.D

29c. License number: AT 2438946

29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chun Hong MD. Union Memorial Hospital, 201 E univ pkwy Baltimore MD 21218

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001

32. Registrar's Signature: ▶ Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02512

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Herbert August Hanson
2. Dete of Death (Month, Day, Year): January 30 2001
3. Time of Death: 1:45AM
4a. Facility Neme (If not institution, give street end number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 394-07-6461
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 84 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/14/1916
9. Birthplace (State or Foreign Country): Wisconsin

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐Yes 2☒No
10a. Street and Number: 9213 Hines Road
10f. Zip Code: 21234
10g. Citizen of Whet Country?: U.S.A.
11. Merital Stetus: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Balto. Gas& Elec.
17. Father's Neme (First, Middle, Last): William A. Hanson
18. Mother's Neme (First, Middle, Maiden Surname): Martha Klatt
19a. Informent's Neme/Reletionship (Type, Print): Adam Preisinger
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 9215 Hines Road Baltimore, Maryland 21234
20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.
Dete: 2/2/01
20c. Location - City or Town, Stete: Baltimore, Maryland
21. Signeture of Funerel Service Licensee: ▶Martin J. Dippel Jr.
22. Name end Address of Feciliity: Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Hanson, Herbert
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)
a. Myocardial Infarction
Due to (or as e consequence of):
b. Coronary Artery Disease
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c. Congestive Heart Failure
Due to (or es e consequence of):
d.

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure; Hypo Albunimeia

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit page.

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶Sohail Mostafa Qarni MD
29c. License number: D-48025
29d. Dete signed (Month, Day, Year): JANUARY 30, 2001

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): SOHAIL QARNI, MD 1224 CHESACO AVENUE, BALTIMORE, MD 21237

State Registrar

31. Dete filed (Month, Day, Year): FEB 1 2001
32. Registrer's Signature: ▶ J. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02513

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Loureen Morant Jones

2. Date of Death Month Day Year: January 31, 2001

3. Time of Death: 9:45 AM

4a. Facility Name *(If not institution, give street and number)*: 1111 Mirga Circle

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 247-38-4655

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT 24, 1929

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1111 Mirga Circle

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cosmetologist

16b. Kind of Business/Industry: Beauty Salon

17. Father's Name *(First, Middle, Last)*: James Morant

18. Mother'a Neme *(First, Middle, Maiden Surname)*: Bernice Davis

19a. Informant's Name/Relationship *(Type, Print)*: Wenona Hill/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1111 Mirga Circle Baltimore, MD 21207

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.

Date: 2/1/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik

Edward A. Gregorchik

22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent cerebrovascular accident

Due to (or as a consequence of):

b. Arterio Sclerotic Cardiac disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Due to (or as a consequence of):

c. Abdominal aortic Aneurysm

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier

29c. License number: D39127

29d. Date signed *(Month, Day, Year)*: February 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Azra Ahmed, M.D. 821 N. Eutaw Street, Ste. 103 Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Bernie G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0425-510

FREDERICK JOHNSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02514

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
FREDERICK JOHNSON	JANUARY 25, 2001	4:33P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNIVERSITY HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
088-42-4724	1☒ M 2☐ F	49 Yrs.			05-13-1951	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
717 W. LAFAYETTE AVE	21217	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	REGISTER NURSE	HEALTH PROGRAM

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
LEO KING	GERTRUDE JOHNSON

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MS, LORRIE LESLIE, SISTER	17 WINLO CT, RANDALLSTOWN, MD 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MOUNT ZION CEMETERY	2-1-01	BALTO. MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Willie E Howell Jr	HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gunshot Wound of Chest
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Naturel 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Panding investigation 6☐ Could not be determined	1/25/01	1555 M	1☐ Yes 2☒ No	Subject Shot

28e. Place of Injury - At home, farm, atraat, factory, office building, etc. (Specify): Street

28f. Location (Straat and Number or Rural Route Number, City or Town, State): 835 North Fremont Avenue Baltimore Maryland

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King MD	O.C.M.E.	JANUARY 26, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King — 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 01 2001	Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02515

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES EDWARD JONES
2. Date of Death: Month: January Dey: 30 Year: 2001
3. Time of Death: 9:04 AM
4a. Facility Name (If not institution, give street and number): ICU UPPER CHESAPEAKE MED CTR
4b. City, Town, or Location of Death: BEL AIR
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 213-46-4689
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4/24/1946
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 111 Walden Road Apt G
10f. Zip Code: 21009
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintanence Mechanic
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Lynal Jones
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Wilson

19a. Informant's Name/Relationship (Type, Print): Terry Martin
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Clipper Road Essex, Maryland 21221

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Balto./Wash. Crematory
Date: 2/3/01
20c. Location - City or Town, State: Laurel, Maryland

21. Signature of Funeral Service Licensee: Curtis A. Gill
22. Name and Address of Facility: John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE ANTERIOR LATERAL MYOCARDIAL
Due to (or as a consequence of): DYSFUNCTION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: OME
29c. License number: OCME
29d. Date signed (Month, Day, Year): Jan 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPNA BHU MD 728 BELAIR RD BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Jones, Charles

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No.: 2001 02516

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles David Keener

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 12:08PM M

4a. Facility Name (If not institution, give street and number): 1029 "C" Old Eastern Avenue

4b. City, Town, or Location of Death: Essex

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 218 28 7538

6. Sex: 1 ☐ M 2 ☐ F — X

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 30, 1932

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No — X

10e. Street and Number: 1029 "C" Old Eastern Avenue

10f. Zip Code: 21221

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter

18b. Kind of Business/Industry: Self Employed

17. Father's Name (First, Middle, Last): Charles Anthony Keener

18. Mother's Name (First, Middle, Maiden Surname): Dorothy Dejohn

19a. Informant's Name/Relationship (Type, Print): Karen Cramer (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 Vincent Avenue Baltimore, Maryland 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gardens — Date: 2/1/01

20c. Location - City or Town, State: Baltimore County, Md

21. Signature of Funeral Service Licensee: M00694

22. Name and Address of Facility: Bruzdzinski Funeral Home PA, 1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Failure

Due to (or as a consequence of):

b. Chronic Obstructive Disease (Pulmonary)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome of pregnancy: 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown

23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F. O'Donnell MD

29c. License number: D-09383

29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F. O'Donnell MD 117 Hamlet Hill Rd Baltimore Md 21210

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02517

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAX KLEIMAN
2. Date of Death (Month, Day, Year): JANUARY 30th 2001
3. Time of Death: 11:05 AM
4a. Facility Name (If not institution, give street and number): LEVINDALE HEBREW HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-01-8856
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAY 7, 1920
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2435 W. BELVEDERE AVENUE
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5+ — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): HYMAN KLEIMAN
18. Mother's Name (First, Middle, Maiden Surname): LIBBY SILVERSTEIN

19a. Informant's Name/Relationship (Type, Print): ARTHUR KLEIMAN / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6511 CHURCH STREET - SYKESVILLE, MD 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BETH TFILOH CEMETERY
Date: 1/31/01
20c. Location - City or Town, State: WOODLAWN, MD

21. Signature of Funeral Service Licensee: Scott M. Cottler
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the daath. Do not enter tha mode of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:
b. DEMENTIA — 1 YEAR
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Deta of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and mannar es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and titie of certifier: Dona M. Eversley M.D.
29c. License number: D 54739
29d. Date signed (Month, Day, Year): JANUARY 30th 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): 2434 West Belvedere Avenue, Baltimore Maryland 21215

State Registrar

31. Data filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Penina D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02518

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gloria K. Loetz
2. Date of Death (Month, Day, Year): January 28, 2001
3. Time of Death: 2:05 PM
4a. Facility Name (If not institution, give street and number): Joseph Richey Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-22-7740
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT 8, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3119 Georgetown Road
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): James Patrick Daly
18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Hadel

19a. Informant's Name/Relationship (Type, Print): Jennifer Ann Jenkins/Granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8836-C Town & Country Blvd. Ellicott City, MD 21043

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 1-29-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Dawn T. McDonald
Dawn T. McDonald

22. Name and Address of Facility: Cremation Society of MD, Inc.
299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of lung — 1 yr.
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) Hospice

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John T. Payne MD
29c. License number: D13012
29d. Date signed (Month, Day, Year): Jan 29, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Payne 4565 N. Charles St 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 0 1 2001
32. Registrar's Signature: Penny Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Gloria Loetz January 28, 2001 2:05 PM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02519

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice Elizabeth Lucas

2. Date of Death — Month: JANUARY Day: 31 Year: 2001

3. Time of Death: 8:50 A.M.

4a. Facility Name *(If not institution, give street and number)*: FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-22-5112

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 11/30/1924

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1204 Back River Neck Road

10f. Zip Code: 21221

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Paper Company

17. Father's Name *(First, Middle, Last)*: Hilbye Mills

18. Mother's Name *(First, Middle, Maiden Surname)*: Madeline Stevens

19a. Informant's Name/Relationship *(Type, Print)*: Diane Pakaski (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1204 Back River Neck Road Essex, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Memorial Gard.

Date: 2/2 2001

20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral Service Licensee: Michael C. Joffin

22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marco Zamora MD

29c. License number: D 40819

29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARCO ZAMORA, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

LUCAS, ALICE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 15 per fh G792 2/1/01 yf

Certificate of Death

Reg. No. 2001 02520

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
BERNARD		LAPIN	January 30 2001	2:10AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-09-5836	X 1 M 2 F	88 Yrs.			JUNE 14, 1912	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2906 LIGHTFOOT DRIVE	21209	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.)	14. Raca - American Indien, Bleck, White, atc.
1 Naver Married 2 X Married 3 Widowed 4 Divorced	1 Yas 2 X No If Yes, Give Yaar or Datas:	1 Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
~~5+~~	4	PHARMACIST	PHARMACY

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
CHARLES LAPIN	ESTHER (UNKNOWN)

19a. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code)
MICHELE SIMONSON / DAUGHTER	1435 FOURTH ST. S.W. UNIT B #104 - WASHINGTON, D.C 20024

20a. Method of Disposition	20b. Piaca of Disposition (Name of cemetery, crematory or other placa)	Date	20c. Location - City or Town, Stete
1 X Burial 2 Cremetion 3 Removal from State 4 Donation 5 X Other (Specify)	CHIZUK AMUNO (ARLINGTON)	1/31/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael Brugo	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heert feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in deeth)	a. pulmonary embolus	5minutes
	Due to (or es a consequence of):	
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in daeth) Lest	b. deep venous thrombosis	4 days
	Due to (or es e consequence of):	
	c.	
	Dua to (or as a consequanca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Wes an eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Wes casa referred to medical examiner?	26. Place of Deeth (Check only one)	
1 Yes 2 X No	Hospitel: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residenca 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigetion 6 Could not be determined		M	1 Yes 2 No	

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) and manner as stated. 2 **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s) end manner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Rosalyn Heese MD	RES-000	January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROSALYN HEESE 600 N Wolfe St Johns Hopkins Hospital Baltimre MD 21287

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrer's Signature
FEB 01 2001	D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

amend item 19b per fh G792 2/1/01 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02521

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CELIA LECHT

2. Date of Death: Month JANUARY Day 27th Year 2001

3. Time of Death: 18:55

4a. Facility Name (If not institution, give street and number): LEVINDALE HEBREW HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-48-2024

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 21, 1909

9. Birthplace (State or Foreign Country): ENGLAND

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2903 FALLSTAFF ROAD #402

10f. Zip Code: 21209

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Neme (First, Middle, Last): AARON GINSBERG

18. Mother's Neme (First, Middle, Maiden Surname): ANNA SWEDLOW

19a. Informent's Neme/Relationship (Type, Print): HERMAN S. LECHT / HUSBAND

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2903 FALLSTAFF ~~ROAF~~ Road #402 - BALTIMORE, MD 21209

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): TAMID LUBAWITZ NUSACH ARI NER

Dete: 1/30/01

20c. Location - City or Town, Stete: ROSEDALE, MD

21. Signeture of Funerel Service Licensee:

22. Neme end Address of Fecility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Intervel Between Onset end Death
Immediete Cause (Finel disease or condition resulting in death)	a. CVA	1 month
Due to (or es e consequence of):		
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest	b. DEMENTIA	3 months
Due to (or es e consequence of):		
	c.	
Due to (or es e consequence of):		
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted.

29b. Signeture end title of certifier: Donna M. Everley M.D

29c. License number: D54739

29d. Date signed (Month, Dey, Yeer): JANUARY 28th 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): 2434 W. Belvedere Avenue, Baltimore Maryland 21215

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 01 2001

32. Registrer's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02522

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM H. MACHER
2. Date of Death (Month, Day, Year): JANUARY 27, 2001
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Genesis Eldercare Heritage Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimroe

Funeral Director

5. Social Security Number: 215-09-7724
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 26, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1001 Gladway Road
10f. Zip Code: 21220
10g. Citizen of What Country?: USA

11. Meritel Status: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Reca - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): maintenance manager
16b. Kind of Business/Industry: bank

17. Father's Name (First, Middle, Last): John Macher
18. Mother's Name (First, Middle, Maiden Surneme): Florence Stubblefield

19e. Informant's Neme/Relationship (Type, Print): Adele Macher/spouse
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1001 Gladway Road Baltimore, MD 21220

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. CORONARY Artery Disease — 2 yrs.

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia.

23b. Did tobacco use contributa to tha causa of death? 1 [ ] Yaa 2 [/] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [/] No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [/] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [/] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [/] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [/] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: S. Rapuano MD
29c. License number: D53720
29d. Date signed (Month, Day, Year): 01/29/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. Rapuano MD, 2112 Belair Rd, #1, Fallston, MD 21047

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02523

MALMO, WILLIAM
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner — **Funeral Director** — **To Be Completed by Funeral Director**

1. Decedent's Name (First, Middle, Last): WILLIAM W. MALMO
2. Date of Death (Month, Day, Year): JANUARY 27 2001
3. Time of Death: 10:40 am
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE
5. Social Security Number: 225-10-4156
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 20, 1916
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8820 Walther Blvd $1514
10f. Zip Code: 21234
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): unk — College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): sales manager
16b. Kind of Business/Industry: automobile
17. Father's Name (First, Middle, Last): Robert Malmo
18. Mother's Name (First, Middle, Maiden Surname): May Beverley
19a. Informant's Name/Relationship (Type, Print): Marion Malmo/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8820 Walther Blvd #1514 Baltimore, MD 21234
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner — **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC CANCER OF BLADDER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sunil Ahuja
29c. License number: D28762
29d. Date signed (Month, Day, Year): JANUARY 27 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUNIL AHUJA MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva B. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02524

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN MILSTEAD
2. Data of Death — Month: January Day: 24 Year: 2001
3. Time of Death: 6:00 pm
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 212-10-9670
6. Sex: 1 [X] M 2 [ ] F
7. Age (If yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Apr 26, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4700 Harford Road
10f. Zip Code: 21214
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 9 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): assistant land clerk
16b. Kind of Business/Industry: state
17. Father's Name (First, Middle, Last): Benoni Milstead
18. Mother's Name (First, Middle, Maiden Surname): Eva Skinner
19a. Informant's Name/Relationship (Type, Print): Nancy Milstead/spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 521 Sussex Road Baltimore, MD 21286
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure
Due to (or as a consequence of):
b. Urinary Tract Infection
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Pneumonia
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal Blood loss

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: P 14582
29d. Date signed (Month, Day, Year): 1/25/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Constance Nduaguba, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Melvin Milstead
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02525

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ronald Joseph McKeldin

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 6:00 AM

4a. Facility Name *(If not institution, give street and number)*: 1946 Hilltop Road

4b. City, Town, or Location of Death: Pasadena

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-24-5263

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 17, 1930

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1946 Hilltop Road

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Yeer or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondary (0-12): 12 / Collega (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: Truck Driver

16b. Kind of Businass/Industry: Trucking

17. Fathar's Nama *(First, Middla, Last)*: Joseph James McKeldin

18. Mothar's Nama *(First, Middla, Maidan Surname)*: Jennie Marie Miller

19a. Informant's Name/Relationship *(Type, Print)*: Linda Blottenberger/Niece

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 1946 Hilltop Road Pasadena, MD 21122

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: Metro Crematory Inc.

Data: 1-31-01

20c. Location - City or Town, Stata: Baltimore, MD

21. Signature of Funaral Service Licensee: Edward A. Gregorchik

22. Nama and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the deeth. Do not entar tha moda of dying, such as cardiac or raspiretory arrast, shock, or heart failura. List *only* ona causa *on* each line.

Approximeta Intarval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. Emphysema End Stage — 3 years

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Undarlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

Cerebrovascular accident

23b. Did tobacco uss contributa to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Wara autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Wes casa rafarrad to medical examinar? 1 [ ] Yas 2 [✓] No

26. Placa of Death *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [ ] Nursing Homa 5 [✓] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Piece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: Gary W. Jones MD

29c. Licansa number: D30111

29d. Data signed *(Month, Day, Year)*: January 30, 2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): 4711 Colonel Ewell Ct Upper Marlboro Md 20772-5925

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Barbara G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02526

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Oscar Jose Mocchi
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 12:45 PM
4a. Facility Name (If not institution, give street and number): 6 Circle Drive
4b. City, Town, or Location of Death: Linthicum
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-66-4698
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR 9, 1931
9. Birthplace (State or Foreign Country): Argentina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Linthicum
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 6 Circle Drive
10f. Zip Code: 21090
10g. Citizen of What Country?: Argentina

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify: Argentinean
14. Race - American Indian, Black, White, etc. Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Meat Cutter
16b. Kind of Business/Industry: Butcher

17. Father's Name (First, Middle, Last): Oscar Silvio Mocchi
18. Mother's Name (First, Middle, Maiden Surname): Franisca Anton

19a. Informant's Name/Relationship (Type, Print): Esmeralda Mocchi/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Circle Drive Linthicum, MD 21090

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory Inc.
Date: 2-1-01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Thomas Gregor
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pancreatic cancer — 3mnths.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Karen Piper MD
29c. License number: D047223
29d. Date signed (Month, Day, Year): 1-31-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karen Piper. MD Kaiser Permanente 7141 Security Blvd Baltimore MD 21244

State Registrar

31. Date filed (Month, Day, Year): FEB 0 1 2001
32. Registrar's Signature: Geneva G Jones

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02527

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanor R. Mann
2. Date of Death (Month, Day, Year): 01 30 2001
3. Time of Death: 8:10 pm
4a. Facility Name (If not institution, give street and number): Broadmead
4b. City, Town, or Location of Death: Cockeysville
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 155-18-7654
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 18, 1919
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Cockeysville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13801 York Road
10f. Zip Code: 21030
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 4 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive
16b. Kind of Business/Industry: Y.W.C.A.
17. Father's Name (First, Middle, Last): William Henry Rath
18. Mother's Name (First, Middle, Maiden Surname): Marian Folsom
19a. Informant's Name/Relationship (Type, Print): W. Berkeley Mann (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13801 York Road Cockeysville, Maryland 21030
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory — Date: 2-1-01
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: George J. Fenane
22. Name and Address of Facility: Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CNS LYMPHOMA	3 mo.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Barbara Carroll, M.D.
29c. License number: D38392
29d. Date signed (Month, Day, Year): 1/31/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARBARA CARROLL, M.D., 13801 YORK RD., COCKEYSVILLE, MD 21030

State Registrar

31. Date filed (Month, Day, Year): FEB 0 1 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02528

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph J. McMULLEN
2. Date of Death: Month January, Day 28, Year 2001
3. Time of Death: 0900 (AM)
4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 093 14 4533
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): April 12 1922
9. Birthplace (State or Foreign Country): New York, New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore County
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2700 Berwick Avenue
10f. Zip Code: 21234
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Security Guard
16b. Kind of Business/Industry: Social Security Administ.

17. Father's Name (First, Middle, Last): Adam Henry Krebs
18. Mother's Name (First, Middle, Maiden Surname): Margaret Mary Henchy

19a. Informant's Name/Relationship (Type, Print): Maureen L Keiser (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 122 Holly Circle Baltimore, Maryland 21221

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Cem. Date: January 31, 2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Heather Rebecca Chenoweth
22. Name and Address of Facility: Lassahn Funeral Home INc 7401 Belair Road Baltimore, Maryland 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease and Congestive Heart Failure

Due to (or as a consequence of):
b. Alcoholic Cirrhosis.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Malnutrition and Malabsorption

Due to (or as a consequence of):
d. Upper Gastrointestinal Bleed.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

History of Gastrectomy (Partial)
History of T.B. (Tuberculosis)

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: 53356
29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Orl Tzuk Good Samaritan Hospital of Baltimore

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02529

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES MOORE
2. Date of Death: Month JANUARY Day 25 Year 2001
3. Time of Death: 14:09
4a. Facility Name (If not institution, give street and number): ST AGNES HEALTH CARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-76-6437
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 40 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 2, 1960
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1644 THOMAS AVE
10f. Zip Code: 21216
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION WORKER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): DAVID W. MOORE
18. Mother's Name (First, Middle, Maiden Surname): CECILIA J.HALL

19a. Informant's Name/Relationship (Type, Print): CECILIA KEITH-MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4901 NELSON AVE BALTIMORE, MD. 21215

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK
Date: 2/1/01
20c. Location - City or Town, State: RANDALLSTOWN, MD.

21. Signature of Funeral Service Licensee: ▶ Lewis T Gwynn LEWIS T.GWYNN
22. Name and Address of Facility: LEWIS T.GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ASPIRATION - SEPSIS SYNDROME	14 HOURS
Due to (or as a consequence of): b.	CHRONIC RENAL FAILURE	MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last. Due to (or as a consequence of): c.	POSSIBLE HIV INFECTION	UNCLEAR
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: ▶ [signature], RESIDENT PHYSICIAN
29c. License number: P-14437
29d. Date signed (Month, Dey, Year): JANUARY, 25, 2001
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): RACHEL ADDO-ASHONG, 900 CATON AVE., BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Dey, Year): FEB 1 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME JAMES MOORE

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02530

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LENA MOSZKOWSKI
2. Date of Death (Month, Day, Year): JANUARY 29 2001
3. Time of Death: 14:39hrs
4a. Facility Name (If not institution, give street and number): SAINT AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 228-34-1686
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR.8,1930
9. Birthplace (State or Foreign Country): GERMANY

Usual Residance of Dacedant

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 3301 SHELBOURNE ROAD
10f. Zip Coda: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yaar or Dates:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Raca - American Indian, Black, White, atc. Specify: WHITE

15. Decedant's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 5+ — Collega (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): SCHOOL TEACHER
16b. Kind of Businass/Industry: EDUCATION

17. Father's Nama (First, Middle, Last): ALFRED IGGERS
18. Mother's Nama (First, Middle, Maidan Surnama): LIZZIE MINDEN

19a. Informant's Name/Ralationship (Type, Print): RONALD MOSZKOWSKI / SON
19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda): M25-OLW 61 RICHMOND AVE.-PRESTWICH,MANCHESTER,GREAT BRITAIN

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of camatary, cramatory or othar placa): BETH JACOB ANSHE VESHEAR — Data: 1/30/01
20c. Location - City or Town, Stata: ROSEDALE, MD

21. Signatura of Funaral Sarvica Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter tha diseesa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on eech lina. — Approximata Interval Batwaen Onsat and Daath

Immediata Causa (Final disease or condition resulting in daath):
a. STAPHYLOCOCCUS AUREUS SEPTICAEMIA — 5 DAYS
Dua to (or as a consaquanca of):
b. NON HODGKINS LYMPHOMA — 2 MONTHS

Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in daath) Last
Dua to (or as e consequanca of):
c.
Dua to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to compilation of causa of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was casa rafarrad to *medical* examiner? 1☐ Yas 2☒ No

26. Placa of Daath (Check only ona)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☒ **Certifying Physician:** To tha best of *my* knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and *mannar* as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in *my* opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and *mannar* stated.

29b. Signatura and title of cartifiar: K Cleary RESIDENT
29c. Licansa number: P-12598
29d. Data signed (Month, Day, Year): JANUARY 29 2001

30. Nama and address of parson who complatad causa of daath (Item 23a) (Type, Print): SIMEON OBENG, 900 CATON AVE, BALTIMORE MD 21229

State Registrar

31. Data filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Bonnie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME Moszkowski, Lena
DOB 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02531

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Morris
2. Date of Death: Month: January Day: 28 Year: 2001
3. Time of Death: 1050 PM
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 053-07-8657
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 12, 1908
9. Birthplace (State or Foreign Country): POLAND

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7920 SCOTTS LEVEL ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROPRIETOR
16b. Kind of Business/Industry: WINDOWS

17. Father's Name (First, Middle, Last): CHAYIMM ISMAHOVITCH
18. Mother's Name (First, Middle, Maiden Surname): FEGEL (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print): VIVIAN ZIMELMAN / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3804 CANDLELITE COURT - FT. WORTH, TX 76109

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NER HAMANAHOT
Date: 1/29/01
20c. Location - City or Town, State: JERUSALEM, ISRAEL

21. Signature of Funeral Service Licensee: Robert Levinson
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 4 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Christopher Davis MD
29c. License number: D0055609
29d. Data signed (Month, Day, Year): January 28 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Davis 2401 West Belvedere Avenue, Baltimore Maryland 21215

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

01-0453-510
jhm
CALVIN A
MARCUS amend item 23a,27,28a-f per me G792 2/5/01 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02532

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CALVIN ANGELO MARCUS SR.

2. Date of Death (Month, Day, Year): JANUARY 27, 2001

3. Time of Death: 06:49 AM

4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-60-4550

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 47 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 9 1953

9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: [X] 1 Yes 2 [ ] No

10e. Street and Number: 236 S MOUNT OLIVET LANE

10f. Zip Code: 21229

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABOR SUPERVISOR

16b. Kind of Business/Industry: TRACY LABOR

17. Father's Name (First, Middle, Last): DAVID MARCUS SR.

18. Mother's Name (First, Middle, Maiden Surname): ERNESTINE GALES

19a. Informant's Name/Relationship (Type, Print): Lois A. Marcus/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5711 Sir Galahag Rd., Glendale Md., 20769

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY

Date: 2/2/01

20c. Location - City or Town, State: BALTIMORE,MARYLAND

21. Signature of Funeral Service Licensee: Charles H. Powell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA
1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND COCAINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined

28a. Date of Injury (Month, Day, Year): found 1/27/01

28b. Time of Injury: found 6:20 a M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State): 236 S. Mt. Olivet Lane Baltimore, Maryland

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jack M. Titus

29c. License number: OCME

29d. Date signed (Month, Day, Year): JANUARY 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 0 1 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02533

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALADEN W. NAGY
2. Date of Death (Month, Day, Year): JANUARY 28, 2001
3. Time of Death: 1:00 PM
4a. Facility Name (If not institution, give street and number): Brook Grove Nursing Home
4b. City, Town, or Location of Death: Sandy Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-30-3471
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 94 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 2, 1906
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Sandy Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 18100 Slade School Road
10f. Zip Code: 20860
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): physicist
16b. Kind of Business/Industry: medical

17. Father's Name (First, Middle, Last): Domokos Nagy
18. Mother's Name (First, Middle, Maiden Surname): Suzanna Buzogany

19a. Interment's Name/Relationship (Type, Print): Susan Nagy/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9514 Crosby Road Silver Spring, MD 20910

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. PNEUMONIA — 24 HOURS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
ADVANCED SENILE DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Howe.
29c. License number: D33700
29d. Date signed (Month, Day, Year): JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 154 N. ARTIZAN ST. WILLIAMSPORT, MD 21795

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Vivian K. Paul

2. Date of Death (Month, Day, Year): JANUARY 30, 2001

3. Time of Death: 00:05 AM

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 220-20-3505

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11 20 27

9. Birthplace (State or Foreign Country): M.D.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 933 North Bentalou Street

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th grade

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Howard Kerr

18. Mother's Name (First, Middle, Maiden Surname): Ellen Jordan

19a. Informant's Name/Relationship (Type, Print): Michael Paul-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3301 Presstman Street, Baltimore Md 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 2/3/01

20c. Location - City or Town, State: Baltimore, Md

21. Signature of Funeral Service Licensee: Jerome A. Thompson

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Myocardial infarction	5 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Coronary artery disease	multiple years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Mesenteric ischemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.C.

29c. License number: D52540

29d. Date signed (Month, Day, Year): JANUARY 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS J. ENELOW, MD ST AGNES HEALTHCARE 900 CATON AVE BALTIMORE, MD 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

VIVIAN K. PAUL

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02535

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick W. Prock
2. Date of Death (Month, Day, Year): Jan. 28 2001
3. Time of Death: 3:17 PM
4a. Facility Name (If not institution, give street and number): Greater Balto. Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 142-26-0816
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 67 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 22, 1933
9. Birthplace (State or Foreign Country): NJ

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Timonium
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2514 Girdwood Road
10f. Zip Code: 21093
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '53-'55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: Communication

17. Father's Name (First, Middle, Last): Matthias Prock
18. Mother's Name (First, Middle, Maiden Surname): Anna Lindner

19a. Informant's Name/Relationship (Type, Print): Helen Prock/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2514 Girdwood Rd., Timonium, MD 21093

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens
Date: 2/2/01
20c. Location - City or Town, State: Timonium, MD 21093

21. Signature of Funeral Service Licensee: Michael J. Flagle
22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. pulmonary embolus
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. metastatic lung cancer
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown
23c. If yes, outcome of pregnancy: 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown
23d. Date of delivery: Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 4 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Elizabeth K. Weed, MD
29c. License number: 035817
29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elisabeth Lucas, M.D. 2328 W. Joppa Rd., Suite 310, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Bruce G. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02536

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
KENNETH	EUGENE	PORTER	JANUARY 30, 2001	10:25 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
722 E. MAPLE ROAD	LINTHICUM HEIGHTS	ANNE ARUNDEL

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-14-0501	1 [X] M 2 [ ] F	78 Yrs.			JUNE 26, 1922	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	LINTHICUM HEIGHTS	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
722 E. MAPLE ROAD	21090	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No 1942-1944	1 [ ] Yes 2 [X] No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		OWNER	SERVICE & TOWING STATION

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
HOLLINGSWORTH	PORTER	MARY	KRALL

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MRS. WANDA M. PORTER (WIFE)	722 E. MAPLE ROAD, LINTHICUM HEIGHTS, MD. 21090

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	GLEN HAVEN MEMORIAL PARK	FEB. 3, 2001	GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ALZHEIMER'S DEMENTIA	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Deta of delivery Month Day Year
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown	1 [ ] Yes 2 [X] No	1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 [ ] Yes 2 [X] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 [ ] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ L. [signature] MD	D0017743	01/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. SEENIVASAN, MD 606 HAMMONDS LN, BALTIMORE, MD, 21225.

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 01 2001	▶ [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02537

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
YVETTE	ROBINSON	JANUARY 29, 2001	10:35 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1500 BEDFORD AVENUE #503	BALTIMORE	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-34-9952	1☐ M 2☒ F	87 Yrs.			MAR. 22, 1913	N.Y.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1☐ Yes 2☒ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1500 BEDFORD AVENUE #503	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JACK OSHER	MOLLY SHAFETZ

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MYRNA POIRIER / DAUGHTER	719 SOUTH ANN STREET - BALTIMORE, MD 21231

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BALTIMORE HEBREW CEMETERY	1/31/01	REISTERSTOWN, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Robert Levinson	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	1 week
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Elliot Rothschild MD	D51426	January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Elliot Rothschild 4000 Old Court Rd. Pikesville, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signeture
FEB 01 2001	per D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02538

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ROGER RINGROSE

2. Dete of Deeth — Month: January; Dey: 31; Yeer: 2001

3. Time of Deeth: 6:35 PM

4e Facility Neme *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Deeth: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 215.01.4464

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Yeer: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: MAY 7, 1919

9. Birthplece *(Stete or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 600 MYERS CT

10f. Zip Code: 21144

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: 44-46

13. Wes Decedent of Hispanic Origin? *(Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)*: 1 [ ] Yes 2 [X] No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: FOREMAN

16b. Kind of Business/Industry: BETHLEHEM STEEL

17. Father's Name *(First, Middle, Last)*: GEORGE W. RINGROSE

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: CATHERINE KELLY

19e. Informent's Neme/Reletionship *(Type, Print)*: JEANNETTE RINGROSE WIFE

19b. Meiling Address *(Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 600 MYERS CT. SEVERN, MD. 21144

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: CROWNSVILLE VET CEM — Dete: 2FEB01

20c. Location - City or Town, Stete: CROWNSVILLE, MD

21. Signeture of Funerel Service Licensee: K. GREGORY FINK MO1148

22. Neme end Address of Fecility: FINK FUNERAL HOME, P.A. 426 CRAIN HWY.S.,GLEN BURNIE,MD. 21061

Physician /Medical Examiner

23a. Pert 1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on eech line.

		Approximete Intervel Between Onset end Deeth
Immediete Cause (Finel diseese or condition resulting in deeth) a.	Cerebral edema	4 days
Due to (or es e consequence of): b.	metastatic Brain tumor	4 days
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last — Due to (or es e consequence of): c.	Lung Cancer, Cyt	4 years
d.		

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Streat end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier:

29c. License number: D18508

29d. Date signed *(Month, Dey, Yeer)*: 01-31-01

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): 600 S. Crain Highway Glen Burnie, md. 2061

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 01 2001

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02539

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carroll Franklin Remley, Sr.

2. Date of Death Month Day Year: January 31, 2001

3. Time of Death: 5:00 AM

4a. Facility Name *(If not institution, give street and number)*: Cherrywood Futurecare

4b. City, Town, or Location of Death: Reisterstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-03-5053

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov 12, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1224 Bachmans Valley Road

10f. Zip Code: 21158

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Raca - American Indian, Bleck, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrical Engineer

16b. Kind of Business/Industry: Joseph Zamoiski Distr.

17. Father's Name *(First, Middle, Last)*: Edwin R. Remley

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Catherine Auld

19a. Informent's Neme/Reletionship *(Type, Print)*: Betty Ann Remley

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 1224 Bachmans Valley Road Westminster, MD 21158

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Ramoval from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: Carroll Cremation Serv.

Dete: 02/01/01

20c. Location - City or Town, State: Hampstead, Maryland

21. Signeture of Funerel Service Licensee ▶ [signature]

22. Name and Address of Fecility: Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death) a. caldiomyopathy ~ 10 yrs

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseesa or injury that initiated events resulting in death) Last

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert Ii. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

Feilure to live

Dementia of aging

23b. Did tobacco uee contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the causa(s) and menner steted.

29b. Signatura and title of certifier ▶ [signature]

29c. License number: D 51705

29d. Date signed *(Month, Dey, Year)*: 1-31-01

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): M. PANSURIYA, MD 419F malcolm Dr, Westminster, MD 21157

State Registrar

31. Dete filed *(Month, Dey, Year)*: FEB 0 1 2001

32. Registrar's Signeture ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02540

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lisa D. Spangler
2. Date of Death: Month 01 Day 16 Year 01
3. Time of Death: 11:00 AM
4a. Facility Name (If not institution, give street and number): Millennium Health Franklin Sq
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 220-72-8634
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 32 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 02-02-68
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1217 W. Fayette Street
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk

17. Father's Name (First, Middle, Last): Tom Spangler
18. Mother's Neme (First, Middle, Meiden Sumeme): Betty Derossett

19a. Informant's Name/Relationship (Type, Print): Betty Spangler/mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code): 101 S. Dean Street Baltimore, MD 21224

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state
20b. Place of Disposition (Neme of cemetery, cremetory or other piece):
Dete:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on aach lina.

Approximete Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death):
a. END-STAGE ACQUIRED IMMUNO DEFICIENCY SYNDROME — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
NUTRITIONAL WASTING; HEPATITIS B; ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year):
28b. Tima of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred:
28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Routa Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred et tha tima, date end place, end dua to tha cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred et the tima, date and place, and due to tha cause(s) and manner steted.

29b. Signature and title of certifier: Robert E. Roby M.D.
29c. License number: D-19425
29d. Date signed (Month, Dey, Year): 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT E. ROBY M.D. - 827 LINDEN AVE, BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

SPANGLER, LISA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02541

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EARL STEVENSON
2. Date of Death (Month, Day, Year): JANUARY 19, 2001
3. Time of Death: 05:39
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 123-28-9974
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 6, 1936
9. Birthplace (State or Foreign Country): unk

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2817 Orleans Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA
11. Marital Status: unk — 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces?: unk — 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unk; College (1-4or 5+): unk
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unk
16b. Kind of Business/Industry: unk
17. Father's Name (First, Middle, Last): unk
18. Mother's Name (First, Middle, Maiden Surname): Margaret Strickler
19a. Interment's Name/Relationship (Type, Print): Johns Hokins Hospital
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 600 Wolfe Street Baltimore, MD 21287
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CIRRHOSIS	2 MONTHS
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David Zaas MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JANUARY 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID ZAAS, MD, JOHNS HOPKINS HOSPITAL, 600 WOLFE STREET, BALTIMORE, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Denise D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02542

AMEND#10c,d,f,& 14 PER F.H. G792 2-1-2001JAB

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY CATHERINE SKETT
2. Date of Death: Month 1 Day 29 Year 2001
3. Time of Death: 4:50 PM
4a. Facility Name (If not institution, give street and number): SON SECOURS HOSPITAL 2000 W. BALTIMORE
4b. City, Town, or Location of Death: BALTIMORE 21223
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214 18 6299
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/27/1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: ~~BALTIMORE~~ CATONSVILLE
10d. Inside City Limits: 1~~☒~~ Yes 2☒ No
10e. Street and Number: RIDGEWAY MANOR N.H. 5743 EDMONDSON AVE BALTIMORE
10f. Zip Code: ~~21218~~ 21228
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: ~~BLACK~~ WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Edward J. Gill
18. Mother's Name (First, Middle, Maiden Surname): Rosa Regina Knell

19a. Informant's Name/Relationship (Type, Print): Mary Jo Dellinger/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Seminole Avenue, Catonsville, MD 21228

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Data: 1/30/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Edward A. Gregorchik
22. Name and Address of Facility: Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	7-10 DAYS
Due to (or as a consequence of):	PNEUMONIA	DAYS-10
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.		
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE
HYPERTENSION
DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): ☒ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Janet V. Mochel, MD
29c. License number: D14949
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JANET V. MOCHEL, MD SON SECOURS HOSPITAL, 2000 W. BALTO. ST MD 21223

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: Donna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#5 PER INFMT. G792 2-5-2001 JAB

Certificate of Death

Reg. No. 2001 02543

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Magdalen Mary Sauer

2. Date of Death Month Day Year: January 30, 2001

3. Time of Death: 5:00 AM

4a. Facility Name (If not institution, give street and number): Dulany Towson Nursing Home

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-12-5379

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/30/1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Essex

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 326 Upperlanding Road

10f. Zip Code: 21221

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cashier

16b. Kind of Business/Industry: Food Store

17. Father's Name (First, Middle, Last): Joseph Altmeyer

18. Mother's Name (First, Middle, Maiden Surname): Katherine Schultz

19a. Informant's Name/Relationship (Type, Print): Ann Mroz (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2616 Holly Beach Road Essex, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cemetery

Date: 2/1 2001

20c. Location - City or Town, State: Overlea, Maryland

21. Signature of Funeral Service Licensee: Jean E. Bruzdzinski

22. Name and Address of Facility: Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dehydration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Suresh K. Tripuraneni

29c. License number: D30661

29d. Date signed (Month, Day, Year): January 30th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Suresh TRIPURANENI 5601 Loch Raven Blvd. Baltimore, Md - 21239.

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02544

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Catherine Sands
2. Date of Death: Month January Day 28 Year 2001
3. Time of Death: 4:30 PM
4e. Facility Name (If not institution, give street and number): 7731 West Drive
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-78-8192
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 56 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 25 1944
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7731 West Drive
10f. Zip Code: 21060
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondery (0-12): 0; College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Disabled
16b. Kind of Business/Industry: Never Worked

17. Father's Neme (First, Middle, Last): James R. Sands
18. Mother's Neme (First, Middle, Meiden Surname): Olive Thompkins

19e. Informent's Neme/Reletionship (Type, Print): Theda Briemann (sister)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 7731 West Drive, Glen Burnie, MD. 21060

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Glen Haven Cemetery
Dete: Jan. 31 2001
20c. Location - City or Town, Stete: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Neme and Address of Facility: Stallings Funeral Home. P.A. 3111 Mountain Road, Pasadena, MD. 21122

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
a. ASCVD
Due to (or es e consequenca of):
b. Atherosclerosis
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coagulopathy
Down syndrome

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Menner of Death: 1☑ Netural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: [signature] Clligatting
29c. License number: D32932
29d. Date signed (Month, Day, Year): January 29, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Carolyn Wyatt, MD 3708 Mountain Rd, Pasadena, MD 21122

State Registrar

31. Dete filed (Month, Dey, Year): FEB 01 2001
32. Registrer's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#5 perFHG792 2/21/2001 EW

Certificate of Death

Reg. No. 2001 02545

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie Stevenson
2. Data of Death Month/Day/Year: January 31, 2001
3. Time of Death: 6:00 a.m.
4a. Facility Name (If not institution, give street and number): Riverview Nursing Center
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 213 ~~231~~-78-4490
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 23,1924
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3209 Glenmore Avenue
10f. Zip Code: 21214
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexicen, Puarto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completad): Elementary/Secondary (0-12): 3 yr's | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Home Maker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Steve Johnson
18. Mother's Name (First, Middle, Meiden Sumema): Rose Nicholas

19a. Informant's Neme/Relationship (Type, Print): Ruby Miller - Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1943 US Highway 64 East Asheboro, N.C. 27203

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Loudon Park | Date: 2/3/01
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Paul L. Harbaugh Jr.
22. Nama and Address of Facility: Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, MD 21214

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediete Ceuse (Final disease or condition resulting in death): a. Hypertensive ~~Arteriosclerotic Coronary Vascular Disease~~ years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Hypothyroidism

23b. Did tobacco use contribute to the cauas of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion ot ceuse ot death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at tha fime, data and place, and due to tha cause(s) and manner stated.

29b. Signatura and title of certifier: Michael Schwartz
29c. License number: D19607
29d. Date signed (Month, Dey, Year): 01-31-2001

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Michael Schwartz,M.D. 7310 Ritchie Highway Suite 508 Glen Burnie, Md 21061

State Registrar

31. Date filed (Month, Dey, Year): FEB 0 1 2001
32. Registrar's Signature: Bonnie D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02546

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT PRESTON STEWART, SR.

2. Date of Death (Month, Day, Year): January 30 2001

3. Time of Death: 1:00am

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare Cromwell Center

4b. City, Town, or Location of Death: Baltimore County

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-03-8373

6. Sex: 1☐M 2☐F — 1X

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 3, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore County

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 8540 Westerman Circle

10f. Zip Code: 21236

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5th grade; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Inspector

16b. Kind of Business/Industry: Leeds Federal S. & L.

17. Father's Name *(First, Middle, Last)*: George Washington Stewart

18. Mother's Name *(First, Middle, Maiden Surname)*: Kostka Signora Young

19a. Informant's Name/Relationship *(Type, Print)*: Robert P. Stewart, Jr. (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8540 Westerman Circle Baltimore, Md. 21236

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: New Cathedral Cemetery

Date: 2-2-2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Martha Lassahn Chojnacki

22. Name and Address of Facility: Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. UTI

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Anemia

Ischemic cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rachelle Gajadhar, MD

29c. License number: D0056705

29d. Date signed *(Month, Day, Year)*: 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3007 E. Northern Parkway Rachelle Gajadhar M.D.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Geneva G. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0479-005
MICHAEL
SAIONTZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02547

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
MICHAEL	B.	SAIONTZ	JANUARY 28, 2001	9:10P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTHWEST HOSPITAL CENTER	RANDALLSTOWN	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-70-7112	1 X M 2 ☐ F	35 Yrs.			MAY 28, 1965	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	OWINGS MILLS	1 ☐ Yes 2 XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11529 GARRISON FOREST ROAD	21117	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		SALES	CEMETERY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MARVIN SAIONTZ	SANDYE BARSHACK

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SANDYE SAIONTZ / MOTHER	3801 CANTERBURY ROAD #501 - BALTIMORE, MD 21218

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CHIZUK AMUNO (ARLINGTON)	1/31/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Jay Alan Lewis	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. OCCLUSIVE PULMONARY THROMBOEMBOLI	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. DEEP LEG VEIN THROMBOSIS	
	Due to (or as a consequence of):	
	c. LEG INJURIES	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown	1 X Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	1/18/01	1928 M	1 ☐ Yes 2 X No	DRIVER OF CAR INVOLVED IN A MOTOR VEHICLE COLLISION
	28e. Place of Injury - At home, ferst, factory, office building, etc. (Specify) HIGHWAY			28f. Location (Street and Number or Rural Route Number, City or Town, State) GOVERNOR RITCHIE HIGHWAY, GLEN BURNIE, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and ptace, and dua to the cause(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ M.D.	O.C.M.E.	JANUARY 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 01 2001	▶ Debra L. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02548

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRENE SCHLEIFER

2. Date of Death: Month JANUARY Day 27, Year 2001

3. Time of Death: 9:50 PM

4a. Facility Name (If not institution, give street and number): SUNRISE OF PIKESVILLE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-03-5773

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): AUG. 19, 1910

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: OWINGS MILLS

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4500 CHAUCER WAY #103

10f. Zip Code: 21117

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ROBERT MEYERS

18. Mother's Name (First, Middle, Maiden Surname): NETTIE PUMPIAN

19a. Informant's Name/Relationship (Type, Print): HELEN SOMMERS / SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4500 CHAUCER WAY - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): (ANSHE EMUNAH) AITZ CHAIM

Date: 1/29/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttler

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary artery disease

Due to (or as a consequence of):
b. Alzheimers Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) Assit Living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Claudes Levin MD

29c. License number: D27075

29d. Date signed (Month, Day, Year): 01-29-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 90 Painters Mill Rd, Ste 126 Owings Mills MD 21117

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02549

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH SHASHO

2. Date of Death (Month, Day, Year): JANUARY 28, 2001

3. Time of Death: 4:50 PM

4a. Facility Name (If not institution, give street and number): 9406 TULSEMERE ROAD

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 097-18-6064

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN.22,1925

9. Birthplace (State or Foreign Country): N.Y.

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE

10c. City, Town or Location: RANDALLSTOWN

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9406 TULSEMERE ROAD

10f. Zip Code: 21133

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MERCHANT

16b. Kind of Business/Industry: ELECTRONICS

17. Father's Name (First, Middle, Last): HENRY SASHO

18. Mother's Name (First, Middle, Maiden Surname): CELIA COHEN

19a. Informent's Name/Relationship (Type, Print): GERTRUDE SHASHO / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9406 TULSEMERE ROAD - RANDALLSTOWN, MD 21133

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): (ANSHE EMUNAH) AITZ CHAIM

Date: 1/29/01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Robert Levinson

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic colon ca — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None Known

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Howard Saiontz, M.D.

29c. License number: Md. # D15552

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard Saiontz M.D. 21 Crossroads Drive * 415 Owings Mills MD 21117

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Jennie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 10c,19b per fh G792 2/1/01 yf

Certificate of Death

Reg. No. 2001 02550

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
ANNABELL	SIRASKY	JANUARY 28, 2001	8:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST. JOSEPH HOSPITAL	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	If Under 1 Year: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-07-7039	1 M 2 X F	80 Yrs.					JUNE 12, 1920	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	~~BALTIMORE~~ Perry Hall	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8713 BLAIRWOOD ROAD #A-4	21236	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
SOL	ROSENBLATT	LIBBY	(UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MELVIN SIRASKY / HUSBAND	8713 BLAIRWOOD ROAD #A-4, Perry Hall ~~BALTIMORE~~, MD 21236

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	MD VETERANS CEMETERY	1/31/01	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CARDIOPULMONARY ARREST	
Due to (or as a consequence of):	b. VENTRICULAR TACHYCARDIA	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. MYOCARDIAL INFARCTION	
Due to (or as a consequence of):	d. DIABETES	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTRIGLYCERIDEMIA

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death (Check only one)
Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA
Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) X

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	D24569	1/29/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
515 FAIRMOUNT AVE SUITE 320, TOWSON

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 01 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02551

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Celestine Taylor
2. Date of Death (Month, Day, Year): January 29, 2001
3. Time of Death: 4:50 pm

4a Facility Name *(If not institution, give street and number)*: Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-28-4133
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 14, 1932
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2618 Orleans Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Surgical Nurse
16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: William Taylor
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Jackson

19a. Informant's Name/Relationship *(Type, Print)*: Michelle Scott (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2618 Orleans Street Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vet Cem
Date: 2/5/01
20c. Location - City or Town, State: Owings Mills, MD.

21. Signature of Funeral Service Licensee: Dennis B. Caple
22. Name and Address of Facility: Dennis B. Caple Funeral Home 4601 York Road Baltimore, Maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	septic shock	12 hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	pneumonia	3 days
Due to (or as a consequence of):		
c.	UTI	3 days
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: K. Wilson MD
29c. License number: AT 24389 46 A9
29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Wilson 201 East University Parkway Baltimore, MD 21218

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 0 1 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02552

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sophie M. Torr

2. Date of Death Month: January Day: 28 Year: 2001

3. Time of Death: 1110 AM

4a. Facility Name *(If not institution, give street and number)*: VANTAGE HOUSE

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 577-16-6369

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: APR. 10, 1913

9. Birthplace *(State or Foreign Country)*: WASH., D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: HOWARD

10c. City, Town or Location: COLUMBIA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5400 VANTAGE POINT ROAD

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5+ College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SOCIAL WORKER

16b. Kind of Business/Industry: SOCIAL WORK

17. Father's Name *(First, Middle, Last)*: JOSEPH MINKIN

18. Mother's Name *(First, Middle, Maiden Surname)*: ROSE MEDNICK

19a. Informant's Name/Relationship *(Type, Print)*: ALAN SHAFER / NEPHEW

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2216 RIDGE ROAD - REISTERSTOWN, MD 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SFARD OHR KNESSETH ISRAEL ANSHE

Date: 1/30/01

20c. Location - City or Town, State: DUNDALK, MD

21. Signature of Funeral Service Licensee: Robert [illegible]

22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — Days

Due to (or as a consequence of): b. Congestive heart failure — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D22856

29d. Date signed *(Month, Day, Year)*: January 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jerry Levine, MD 11055 Little Patuxent Pky, Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02553

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM LOUIS WILCZENSKI

2. Date of Death (Month, Day, Year): JANUARY 27, 2001

3. Time of Death: 12:08 PM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-30-5281

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 25, 1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Riva

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2703 Riva Road

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: '57-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): bricklayer

16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): Antony Edward Wilczenski

18. Mother's Name (First, Middle, Maiden Surname): Martha Ellen Coy

19a. Informant's Name/Relationship (Type, Print): Carol Wilczenski/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2703 Riva Road Annapolis, MD 21401

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Heart Failure — 11 ds

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Coronary Artery Disease — years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Diabetes Mellitus

kidney Failure

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sjoerd Beck, MD

29c. License number: D 46052

29d. Date signed (Month, Day, Year): 11/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sjoerd Beck, MD 64 Franklin Street Annapolis, MD 21401

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001

32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0492-510
crn
Victor White

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02554

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VICTOR PHILLIP WHITE
2. Date of Death Month / Day / Year: January 30, 2001
3. Time of Death: 12:55 A.M.
4a. Facility Name *(If not institution, give street and number)*: 500 Block of North Gilmor Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-02-1102
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 18 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: AUG. 9, 1982
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 707 W. CUMBERLAND ST
10f. Zip Code: 21217
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th — College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NONE
16b. Kind of Business/Industry: NA
17. Father's Name *(First, Middle, Last)*: PHILLIP VICTOR WHITE
18. Mother's Name *(First, Middle, Maiden Surname)*: BARBETTE LITTLEJOHN
19a. Informant's Name/Relationship *(Type, Print)*: BESSIE LITTLEJOHN (GRANDMOTHER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 707 W. CUMBERLAND ST BALTIMORE, MD 21217
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT ZION CEMETERY
Date: FEB. 3, 01
20c. Location - City or Town, State: LANSDOWN, MD
21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Gunshot Wounds
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown
24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No
25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* at scene
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 1/30/01
28b. Time of Injury: 0045 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Street
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Baltimore, Maryland
29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ J. Pestaner MD.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 30, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date Filed *(Month, Day, Year)*: FEB 1 2001
32. Registrar's Signature: ▶ Denise B. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02555

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IRMA WELSH WILLIAMS
2. Date of Death — Month: JANUARY Day: 30, Year: 2001
3. Time of Death: 11:30 AM
4a. Facility Name (If not institution, give street and number): GLEN MEADOWS RETIREMENT COMMUNITY
4b. City, Town, or Location of Death: GLEN ARM
4c. County of Death: BALTIMORE COUNTY

Funeral Director

5. Social Security Number: 213-05-2358
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 18, 1913
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2850 NORTH CHARLES STREET APT. 11B
10f. Zip Code: 21218
10g. Citizen of What Country?: UNITED STATES OF AMERICA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PRINTING INTERNAL REVENUE
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): ANDREW M. WELSH
18. Mother's Name (First, Middle, Maiden Surname): ELSIE B. ZIMMERMAN

19a. Informant's Name/Relationship (Type, Print): W. DONALD WILLIAMS/STEP-SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1316 SWEETBRIAR LANE/BEL AIR, MARYLAND 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): PARKWOOD MAUSOLEUM
Date: FEB. 1, 2001
20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Donald R. Watson, Jr. #M00612
22. Name and Address of Facility: ALTENBURG FUNERAL HOME, P.A. 6009 HARFORD ROAD BALTIMORE, MD. 21214

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. multiple strokes with — years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. oral pharyngeal dysphagia
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley M.D.
29c. License number: D25285
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 01 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #29c per DVRG792 2/5/2001 EW

Certificate of Death

Reg. No. 2001 02556

Watson, Tiffany

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: TIFFANY MONIQUE WATSON

2. Date of Death (Month, Day, Year): January 26 2001

3. Time of Death: 5:18 pm

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-06-4228

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 16 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 20 1984

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 40 MARICE CIRCLE

10f. Zip Code: 21221

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STUDENT

16b. Kind of Business/Industry: CHESAPEAKE H.S.

17. Father's Name *(First, Middle, Last)*: GEORGE ISHMAN LEACH

18. Mother's Name *(First, Middle, Maiden Surname)*: PATRICIA ANN WATSON ROYSTER

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Royster/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 40 Marice Circle, Baltimore, Maryland 21221

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: WESTERN CEMETERY

Date: 2-3-01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: Charles A. Powell

22. Name and Address of Facility: WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Anoxic Brain Injury — 36 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Stephen Selinger MD

29c. License number: D 28717

29d. Date signed *(Month, Day, Year)*: January 26 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR Stephen Selinger 9000 Franklin Square Drive Baltimore Maryland 21237

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 01 2001

32. Registrar's Signature: Geneva G Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

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ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02557

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William NMN Busse
2. Date of Death Month Day Year: January 11, 2001
3. Time of Death: 0100
4a. Facility Name *(If not institution, give street and number)*: Heron Point
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 140-01-9438
6. Sex: X 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 12, 1908
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: 1☒ Yes X 2☐ No
10e. Street and Number: 501 Campus Avenue
10f. Zip Code: 21620
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No X — Specify:
14. Race - American Indian, Black, White, etc. — Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales & Advertising
16b. Kind of Business/Industry: Construction Equipment

17. Father's Name *(First, Middle, Last)*: William Carl Busse
18. Mother's Name *(First, Middle, Maiden Surname)*: DAisey Schwannecke

19a. Informant's Neme/Reletionship *(Type, Print)*: Ann B. Kellan
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 324 Lime Landing Road, Millington, Maryland 21651

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation Ctr. LLC. — Date: January 12, 2001
20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: ▶ William L. King, Jr. M-00937
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 Cypress Street, Millington, Maryland 21651

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive Heart Failure	3 Months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part t.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No X 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No X
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No X
26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home X 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel X 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner es steted. 2☐ **Medtcal Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶
29c. License number: D-0013824
29d. Date signed *(Month, Day, Year)*: Juanuary 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. John Seymour 122 Speer Road, Chestertown, Maryland 21620

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 2001
32. Registrer's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: #8 PER F.H. G794 4-21-01 WR.
Amended item#31,(per TCHD),01-04-01,EW,Talbot

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02558

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Ruth	B.	Brinsfield	January 3, 2001	12:10pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WILLIAM HILL MANOR	EASTON	TALBOT

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-48-2294	1☐ M 2☒ F	94 Yrs.			NOV. 21 1906 ~~1904~~	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	TALBOT	EASTON	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
501 DUTCHMAN'S LANE	21601	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	2	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GEORGE M. BACHTELL	EMMA SPESSARD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CARROLL S. BRINSFIELD III/SON	PO BOX 507, OXFORD, MD 21654

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SPRING HILL CEMETERY	01-06-01	EASTON, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ M. E. Newman III CFSP	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gastro intestinal hemorrhage	12hrs
Due to (or as a consequence of):	b. Disseminated Intravascular Coagulation	12hrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Ischemic Colitis	24hrs
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DJD Knees.
GERD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Wm H Wood Jr MD	D08715	1/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
WILLIAM H. WOOD, JR M.D. 505 DUTCHMANS LANE ~~EASTON~~, MD ~~21601~~

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 04 2001 ~~JAN 04 2001~~ JAN 0 4 2001	~~Deputy~~ Registrar B. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02559

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BETTY RUTH BRATKOWSKI

2. Date of Death (Month, Day, Year): January 11 2001

3. Time of Death: 10:40 p.m.

4a. Facility Name (If not institution, give street and number): Wicomico Nursing Home

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 215-05-7987

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 9, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6007 Walston Switch Road

10f. Zip Code: 21804

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elamantery/Secondery (0-12): 8

College (1-4or 5+): –

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Uriah Wooten

18. Mother's Name (First, Middle, Maiden Surname): Lottie Decans

19a. Informent's Name/Reletionship (Type, Print): Donald Bratkowski/Son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6007 Walston Switch Rd., Salisbury, MD 21804

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Salisbury Crematory

Date: 1/15/01

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: Keith K Downey CFSP

22. Name and Address of Facility: Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respirelory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel disaase or condition resulting in deeth)

a. Pneumonia

Due to (or es a consequence of):

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initiated events rasulting in deeth) Last

b. Dysphagia with Aspiration

Due to (or es e consequence of):

c. Stroke (Cerebrovascular Accident)

Due to (or es a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es steted. 2☐ Medical Examiner: On the basis of examinetion end/or Investigetion, In my opinion, deeth occurred et the time, date end piece, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: Scott Rifkin MD

29c. License number: D34145

29d. Date signed (Month, Day, Year): 1/15/01

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Scott Rifkin MD 21 Crossroads Dr Owings Mills MD 21117

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Betty Bratkowski

w, c

3+2 DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02560

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Zennia F. Casteel

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 10:37A.M.

4a. Facility Name (If not institution, give street and number): 58 Hollingsworth Manor

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 232-62-7096

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 4, 1910

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 58 Hollingsworth Manor

10f. Zip Code: 21921

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress

16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Charles Gwaltney

18. Mother's Name (First, Middle, Maiden Surname): Berdie Reedy

19a. Informant's Name/Relationship (Type, Print): Auburn P. Casteel-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 704 River Manor Dr. North East Md. 21901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Elkton Cemetery

Date: 1/18/01

20c. Location - City or Town, State: Elkton, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Gee Funeral Home 259 E. Main St. Elkton, Md. 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimer's Dementia — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Monte Makous, MD

29c. License number: D-44783

29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MONTE MAKOUS, MD 111 West High Street, ELKTON, MD 21921

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02561

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Paul Marvin Cronshaw
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 3:05 am
4a. Facility Name *(If not institution, give street and number)*: Residence: 23A Owens Landing
4b. City, Town, or Location of Death: Perryville
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-20-8681
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 71 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 26, 1929
9. Birthplace *(State or Foreign Country)*: Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 23A Owens Landing
10f. Zip Code: 21903
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Eleven Years; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Worker
16b. Kind of Business/Industry: General Motors Wilmington, Delaware

17. Father's Name *(First, Middle, Last)*: James Henry Cronshaw
18. Mother's Name *(First, Middle, Maiden Surname)*: Rosa Lee Morris

19a. Informant's Name/Relationship *(Type, Print)*: Bessie Ida Cronshaw
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 23A Owens Landing, Perryville, Maryland 21903

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sudlersville Cemetery
Date: 1/20/01
20c. Location - City or Town, State: Sudlersville, Maryland

21. Signature of Funeral Service Licensee: Thomas M. Patterson, Sr.
22. Name and Address of Facility: Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER — Five Months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mike B. Gibson MD
29c. License number: D0054563
29d. Date signed *(Month, Day, Year)*: JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIKE GIBSON JOHNS HOPKINS ONCOLOGY CENTER

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Geneva D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02562

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELZIE ELBERT CHRISTY JR.

2. Date of Death — Month: January Day: 16 Year: 2001

3. Time of Death: 13:57

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 215-56-2183

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Day, Year): Jan 8 1949

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Kent

10c. City, Town or Location: Sassafras

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 33467 Sassafras Caldwell Rd.

10f. Zip Code: 21635

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1968 -1971

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Home Repairs

17. Father's Neme (First, Middle, Last): Elzie Christy Sr.

18. Mother's Name (First, Middle, Maiden Surname): Naomi Brown

19a. Informant's Neme/Relationship (Type, Print): Darius Christy (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 112 E. Lockwood St. Middletown, DE. 19709

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory, or other placa): Eastern Shore Veteran's Cemetery

Date: 1/22/01

20c. Locetion - City or Town, State: Hurlock, MD.

21. Signature of Funeral Service Licensee: [signature] M00510

22. Nama and Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart lailura. List only one cause on each line.

Approximata Interval Between Onset and Deeth

Immediete Cause (Final disease or condition resulting in deeth)

a. Ventricular fibrillation — 30 minute

Due to (or es e consequence ol):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events rasulting in death) Last

b.

Due to (or as a consequence ol):

c.

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I: Hypertension, Chronic renal failure

23b. Did tobacco uaa contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy lindings available prior lo completion of cause of deeth? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Netural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Couid not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, lactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best ol my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D28339

29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address ol person who completed cause of death (Item 23a) (Type, Print): LINDA [illegible] 101 E. Wheel Road Bel Air, MD 21015

State Registrar

31. Data filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02563

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Florence E. Campbell

2. Date of Death Month Day Year: January 18, 2001

3. Time of Death: 07:20 AM

4a. Facility Name *(If not Institution, give street and number)*: Laurelwood Nursing Center

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 195-28-4835

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 15, 1938

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 31 Leedle Circle

10f. Zip Code: 21911

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sewing Machine Operator

16b. Kind of Business/Industry: Textile

17. Father's Name *(First, Middle, Last)*: Everett B. Herr

18. Mother's Name *(First, Middle, Maiden Surname)*: Velvie E. Underwood

19a. Informant's Name/Relationship *(Type, Print)*: Mary Herr / Sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 61 Leedle Circle, Rising Sun, Maryland 21911

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*: Little

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Little Britain Presbyterian Cemetery | Date: January 22,2001

20c. Location - City or Town, State: Little Britain, Pennsylvania

21. Signature of Funeral Service Licensee: Robert H. Crouch

22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Monte Makous, MD

29c. License number: D-44783

29d. Date signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MONTE MAKOUS, MD 111 WEST High STREET, ELKTON, MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: D. [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

rgw

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02564

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Katherine Anthony Clements
2. Date of Death Month Dey Year: January 16, 2001
3. Time of Death: 1:30 am
4a. Facility Name *(If not institution, give street and number)*: Chestertown Nursing & Rehab. Center
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 197-07-4670
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 1, 1916
9. Birthplace *(State or Foreign Country)*: Kingstown, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 104 Mimosa Road
10f. Zip Code: 21620
10g. Citizen of What Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+): 3
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: E. Rumsey Anthony
18. Mother's Name *(First, Middle, Meiden Sumeme)*: Rebecca Rigley

19e. Informent's Name/Reletionship *(Type, Print)*: Alday Merrick Clements
19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 104 Mimosa Road, Chestertown, MD 21620

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Cremation Center, LLC | Date: 1/17/2001
20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)
a. Respiratory failure — 10 days
Due to (or as a consequence of):
b. Multiple Cerebrovascular Accidents.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
CVA Multiple ; HTN ; Hx MI ; CAD, c Stent ;
↑ Chol ; Hx Sub Dural Hematoma ; Gout.

23b. Did tobacco use contribute to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2☐ **Medicaf Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) end manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D50996
29d. Dete signed *(Month, Day, Year)*: 1/16/01
30. Neme and address of person who completed ceuse of death (Item 23e) (Type, Print): Neil Stoddard MD 100 Brown St Medical Office Building Chestertown MD 21620

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02565

J. CLARENCE CHIDESTER 236-03-9223 Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

11
MS

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name *(First, Middle, Last)*: J. CLARENCE CHIDESTER
2. Date of Death: Month 01 Day 15 Year 2001
3. Time of Death: 9:55 PM
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany
5. Social Security Number: 236-03-9223
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 83 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 23, 1917
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: WV
10b. County: MINERAL
10c. City, Town or Location: RIDGELEY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 35 SECOND AVENUE
10f. Zip Code: 26753
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ELECTRICIAN & SUPERVISOR
16b. Kind of Business/Industry: B & O RAILROAD
17. Father's Name *(First, Middle, Last)*: J. CLARENCE CHIDESTER
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA DELL LARUE
19a. Informant's Name/Relationship *(Type, Print)*: BARBARA HUFF / DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 323, RIDGELEY, WV 26753
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORT ASHBY CEMETERY
Date: 01/18/2001
20c. Location - City or Town, State: FORT ASHBY, WV
21. Signature of Funeral Service Licensee: Howard D. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intracerebral Hemorrhage — 2 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Robustiano J. Barrera
29c. License number: D0014865
29d. Date signed *(Month, Day, Year)*: JANUARY 17, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BARRERA, ROBUSTIANO J., M.D., 500 MEMORIAL AVENUE, SUITE 201, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: George D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02566

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Waneta GRACE Chiccarella
2. Date of Death: Month January Day 2 Year 2001
3. Time of Death: 04:23Am
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-26-9564
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCTOBER 14 1931
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: PA.
10b. County: BEDFORD
10c. City, Town or Location: CLEARVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3506 CHANEYSVILLE ROAD
10f. Zip Code: 15535
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12; College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): AMOS EARL JOHNSON
18. Mother's Name (First, Middle, Maiden Surname): MELISSA BELLE RUBY

19a. Informant's Name/Relationship (Type, Print): DONALD CHICCARELLA HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3506 CHANEYSVILLE ROAD CLEARVILLE, PA. 15535

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CUMBERLAND CREMATORY
Date: JAN 5 2001
20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmia — 8minutes
Due to (or as a consequence of):
b. Cardiomyopathy — 4years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] medical doctor
29c. License number: RES-000
29d. Date signed (Month, Day, Year): January 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Geoffrey Nguyen, 600 N. Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 04 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Replacement 1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02567

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
HENRY CLARKE	01	02	2001	9:50 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LORIEN NURSING HOME	RIVERSIDE	HARFORD

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
147-64-4621	1☒M 2☐F	90 Yrs.			03-10-09	ST. MARY,JAMAICA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	hARFORD	BELCAMP	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1123 BELCAMP ROAD	21017	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes ☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		ENTREPRENEUR/LAND OWNER	REAL ESTATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN	UNKNOWN

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NORMAN CLARKE / SON	528 E. BROADWAY, BEL AIR, MD 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	CHESTNUT GROVE	1-06-01	STREET, MD 21154

21. Signature of Funeral Service Licensee: George Tittle

22. Name and Address of Facility: TITTLE'S FUNERAL SERVICES 3836 OLD FEDERAL HILL RD, JARRETTSVILLE, MD 21084

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MYOCARDIAL INFARCTION	
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer, Anemia

Multi-Infarct Dementia

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D27975	01/03/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID MCCLURE MD 615 MACPHAIL RD BEL AIR MD 21014

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 05 2001	Geneva D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HARFORD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02568

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM E. CROOKS

2. Date of Death: Month JAN Day 18 Year 2001

3. Time of Death: 5:25 AM

4a. Facility Name (If not institution, give street and number): CUMBERLAND NURSING HOME

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 255-10-1230

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 99 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN 1, 1902

9. Birthplace (State or Foreign Country): ENGLAND

Usuel Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: LAVALE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6 LINDA WAY

10f. Zip Code: 21502

10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decadent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4+

16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER

18b. Kind of Business/Industry: FIBER/TEXTILE

17. Father's Name (First, Middle, Last): HENRY CROOKS

18. Mother's Neme (First, Middle, Maiden Surname): LEAH BLACKBURN

19a. Informant's Name/Relationship (Type, Print): WILLIAM E. CROOKS-SELF

19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, State, Zip Coda): 6 LINDA WAY, LAVALE, MD 21502

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removel from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemafary, crematory or other place): SUNSET HILL MEMORIAL GARDENS

Data: JAN 24,2001

20c. Location - City or Town, State: ROME, GA

21. Signature of Funeral Service Licensee: Douglas A Hafer

22. Nama and Addrass of Faciliry: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)

a. Coronary artery disease — 10 years

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings evelieble prior to compietion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [ ] inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Othar: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding invastigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Phyaician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated. 2 [ ] **Medical Examinar**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, date and placa, and due to the cause(s) and mannar stated.

29b. Signatura end titla of certifier: [signature]

29c. License number: D0033280

29d. Date signed (Month, Day, Year): Jan 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. S. GUPTA, 625 KENT AVE., CUMBERLAND, MD 21502

State Registrar

31. Dete filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15
MD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02569

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRASHIER LEOTA DOWDEN

2. Date of Death — Month: January Day: 11 Year: 2001

3. Time of Death: 1845

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 233-74-2381

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 2,1907

9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. State: WV

10b. County: MINERAL

10c. City, Town or Location: FORT ASHBY

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: ROUTE 28

10f. Zip Code: 26719

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: JOHN WESLEY BURKETT

18. Mother's Name *(First, Middle, Maiden Surneme)*: ANNA MARY INSKEEP

19a. Informant's Name/Reletionship *(Type, Print)*: CAROLINA SEE / DAUGHTER

19b. Malting Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: P.O. BOX 97, FORT ASHBY,WV 26719

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: FORT ASHBY CEMETERY

Date: 01/15/2001

20c. Location - City or Town, State: FORT ASHBY,WV

21. Signature of Funerel Service Licensee: Sheryl R. Upchurch

22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finat disease or condition resulting in death)	a. Gangrene both lower extremities	2 days
Due to (or as a consequence of):		
Sequentially list conditions, If any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b. Cholesterol Embolism	2 days
Due to (or as a consequence of):		
	c. Repair abdominal aortic aneurysm	2 days
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Severe renal failure

23b. Did tobacco use contributs to the causs of death? 1☐ Yss 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Ptece of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and plece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Sivan Pillai

29c. License number: D13233

29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Sivan Pillai M.D. 915 Seton Drive Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: Barbara G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02570

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna Janet Dyson
2. Date of Death Month Day Year: Jan. 17, 2001
3. Time of Death: 7:15 am
4a. Facility Name *(If not institution, give street and number)*: 500C Carter Court
4b. City, Town, or Location of Death: Perryville
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 217-64-0444
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 48 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 26, 1952
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Perryville
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 500C Carter Court
10f. Zip Code: 21903
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engraver
16b. Kind of Business/Industry: Printing

17. Father's Name *(First, Middle, Last)*: James Richard Dyson, Jr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Susie D. Banks

19a. Informant's Name/Relationship *(Type, Print)*: James C. Dyson / Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2711 Shawn Ct., Fort Washington, MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. James Cemetery — Date: 1/22/01
20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: ▶ Lisa Scott
22. Name and Address of Facility: Lisa Scott Funeral Home, 552 Lewis Street, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute exacerbation congestive heart failure — 2 days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation
Diabetes Mellitus
obesity Rt gluteal wound

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Baig MIRZA A-BAIG MD
29c. License number: DG 3115
29d. Date signed *(Month, Day, Year)*: 1-19-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mirza A. Baig, M.D., 615 South Union Ave., Havre de Grace, Md. 21078

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: ▶ Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

VD

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02571

Marion Ewing 1-15-01 8:30AM D.O.B 12-2817 SS#217-36-0604 Dr. Wun

Physician /Medical Examiner

Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): Marion Ewing		2. Date of Death: Month January Day 15 Year 2001	3. Time of Death: 8:30 a.m.
4a. Facility Name (If not institution, give street and number): Corsica Hills Nursing Home	4b. City, Town, or Location of Death: Centreville	4c. County of Death: Queen Anne's	
5. Social Security Number: 217-36-0604	6. Sex: 1 [X] M 2 [ ] F	7. Age (In yrs. last birthday): 84 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)	8. Date of Birth (Month, Day, Year): December 28, 1916
9. Birthplace (State or Foreign Country): Centreville, MD			

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Kent	Chestertown	1 [ ] Yes 2 [ ] No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
101 Malone Avenue	21620	USA

11. Meritai Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.)	14. Race - Americen Indien, Bleck, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grede completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12): 8	College (1-4or 5+):	Farmer	Agriculture

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Lawrence Edward Ewing	Bertie Draper

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Ruth Eloise Ewing	101 Malone Avenue, Chestertown, Maryland 21620

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)	Chester Cemetery	1/18/2001	Chestertown, Maryland

21. Signeture of Funerel Service Licensee: Fellows, Helfenbein & Newnam Funeral Home, P.A.

22. Neme end Address of Feclity: 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Ceuse (Final diseese or condition resulting in deeth)	e. Myelodysplasia	a few years
	Due to (or as a consequence of):	
Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Last	b. Due to (or es e consequence of):	
	c. Due to (or es e consequence of):	
	d.	

Pert II. **Other eignificant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

① AsHD.

23b. **Did tobacco ues contribute to the cause of death?** 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings eveileble prior to completion of ceuse of death?
1 [ ] Yes 2 [✓] No	1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer?	26. Piece of Deeth (Check only one)	
1 [ ] Yes 2 [✓] No	Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA	Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth	28a. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 [✓] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.
2 [ ] **Medical Examiner:** On the besis of exemination and/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
Ken K. Wun, MD.	D21313	1/15/01

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): KIN K. WUN, 415 Washington Ave., Chestertown, MD 21620

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State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signature
JAN 17 2001	Denise B. Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02572

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Harold Folk

2. Date of Death (Month - Day - Year): 1 - 18 - 2001

3. Time of Death: 2:35 AM

4a. Facility Name (If not institution, give street and number): Frostburg Village Nursing Care Center

4b. City, Town, or Location of Death: Frostburg

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-14-7980

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 14-Dec-21

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Mount Savage

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 12605 Bruce House Road, N.W.

10f. Zip Code: 21545-

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): orderly

16b. Kind of Business/Industry: nursing home

17. Father's Name (First, Middle, Last): Charles Keely Folk

18. Mother's Name (First, Middle, Maiden Surname): Celia Rawlings

19a. Informant's Name/Relationship (Type, Print): Nellie Folk wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12605 Bruce House Road, N.W. Mount Savage Maryland 21545-

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Lawn Memorial Gardens

Date: 21-Jan-01

20c. Location - City or Town, State: LaVale, Maryland

21. Signature of Funeral Service Licensee: John R Durst

22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Myocardial Infarction	10 minutes
Due to (or as a consequence of): b.	Coronary Thrombosis	10 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Coronary artery Disease	40 years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Severe Parkinsons Disease with Dementia. COPD. Psychosis

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: S L Sandhir MD

29c. License number: D14464

29d. Date signed (Month, Day, Year): Jan 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. L. Sandhir, M.D., 48 Tam Terrace, Frostburg, Maryland 21532

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: George D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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MS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #19B PER F.H. G793 3-19-01 WR

Certificate of Death

Reg. No. 2001 02573

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Archer GARNER

2. Date of Death (Month, Day, Year): January 13, 2001

3. Time of Death: 8:00 am

4a. Facility Name (If not institution, give street and number): Solomons Nursing Center

4b. City, Town, or Location of Death: Solomons

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 217 52 8388

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 101 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 2, 1899

9. Birthplace (State or Foreign Country): Wash., DC

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Chesapeake Beach

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3502 Bayview Drive

10f. Zip Code: 20732

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): docket clerk

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Charles Irving Archer

18. Mother's Name (First, Middle, Maiden Surname): Emma Roma Stansbury

19a. Informant's Name/Relationship (Type, Print): Richard N. Garner (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3502 BAYVIEW DR. CHESAPEAKE BEACH, MD 20732 ~~Same as 10 above~~

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 1-18-01

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE — 5 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Zahir Yousaf MD

29c. License number: D0027189

29d. Date signed (Month, Day, Year): 01/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zahir Yousaf, M.D. Huntingtown, MD 20639

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Benna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02574

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Grace E. Gibney
2. Date of Death Month / Day / Year: January 22, 2001
3. Time of Death: 12:20 am
4a. Facility Name *(If not institution, give street and number)*: 187 Pierce Rd.
4b. City, Town, or Location of Death: Rising Sun
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-42-6768
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 7, 1911
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Rising Sun
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 187 Pierce Rd.
10f. Zip Code: 21911
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Alfred P. Byers
18. Mother's Name *(First, Middle, Maiden Surname)*: Clara McNaughton

19a. Informant's Name/Relationship *(Type, Print)*: Ruth B. Fulmer/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1802 Bryce Drive, Wilmington, DE 19810

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rosebank Cemetery — Date: 1-25-01
20c. Location - City or Town, State: Rising Sun, Maryland

21. Signature of Funeral Service Licensee: Richard L. Goodie
22. Name and Address of Facility: R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure
Due to (or as a consequence of):
b. congestive heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus; Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Shauna Marie Paylor MD
29c. License number: D0050195
29d. Date signed *(Month, Day, Year)*: January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHAUNA MARIE PAYLOR MD 101 Colonial Way, Rising Sun, Maryland 21911

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

rgw

10

01-0249-029
CJ
Benita S. Hyland

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,27,28a-f per M.E. G792 020201 SS

Certificate of Death

Reg. No. 2001 02575

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Benita Spry Hyland
2. Date of Death: Month January, Day 15, Year 2001
3. Time of Death: 07:15 A.M.
4a. Facility Name (If not institution, give street and number): 10712 Horseshoe Lane
4b. City, Town, or Location of Death: Worton
4c. County of Death: Kent

Funeral Director

5. Social Security Number: 216-40-3843
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Data of Birth (Month, Day, Year): October 20, 1942
9. Birthplace (State or Foreign Country): Chestertown, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Worton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10712 Horseshoe Lane
10f. Zip Code: 21678
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John B. Spry, Sr.
18. Mother's Name (First, Middle, Maiden Surname): June Maslin

19a. Informant's Name/Relationship (Type, Print): William Edward Hyland, Sr.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 187, 10712 Horseshoe Lane, Worton, MD 21678

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Center, LLC
Date: 1/19/2001
20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. VENLAFAXINE INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify): Scene

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28b. Time of Injury: Unknown M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Unknown
28e. Date of Injury (Month, Day, Year): 1-15-01
28f. Location (Street and Number or Rural Route Number, City or Town, State): 10712 Horseshoe Lane Worton, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 16, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aaron Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02576

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HERMAN MONROE HENRY

2. Date of Death: Month 01 Day 13 Year 01

3. Time of Death: 1:45p

4e. Facility Name (If not institution, give street and number): KENT & QUEEN ANNE'S HOSPITAL

4b. City, Town, or Location of Death: CHESTERTOWN

4c. County of Death: KENT

Funeral Director

5. Social Security Number: 220-01-8452

6. Sex: 1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 09. 15. 1901

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10e. State: MD

10b. County: KENT

10c. City, Town or Location: CHESTERTOWN

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8550 CAULKS FIELD ROAD

10f. Zip Coda: 21620

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Navar Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - Amarican Indian, Black, White, atc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH | College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): FACTORY

16b. Kind of Business/Industry: VITA FOODS

17. Father's Name (First, Middle, Last): ISAAC HENRY

18. Mother's Name (First, Middle, Meiden Sumame): CATHERINE ELIZABETH BROOKENS

19e. Informent's Name/Reletionship (Type, Print): LYCUGUS HENRY. SON

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1882 GEORGETOWN RD CHESTERTOWN, MD 21620

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramovel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): ASBURY U.M. CEMETERY | Dete: 01.17.01

20c. Location - City or Town, State: CHESTERTOWN, MD

21. Signatura of Funaral Service Licensee: Joyce O. Walley

22. Name and Address of Facility: WALLEY FUNERAL SERVICES. CHESTERTOWN, MD 21620

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or hae'r failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel diseese or condition resulting in deeth) e.	Urosepsis	3day
Due to (or es a consequence of):		
b.	Pneumonia, bilateral	1day
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest — Due to (or as a consequence of):		
c.		
Due to (or es a consequence of):		
d.		

Part II. **Other significant conditione** contributing to death but not resulting in tha underlying cause given in Pert I.: Hypertension, Paget's

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to compietion of causa of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Piece of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: ☒ 1 Naturei 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) end manner as stated. 2 ☐ **Medicat Examinar:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the fime, date end place, and due to the cause(s) and manner stafed.

29b. Signeture and title of certifier: MD

29c. Licansa numbar: D0051735

29d. Dete signed (Month, Dey, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR FREDERICK W. DELBOY. ROUND TOP PROF. BLDG. 6602 CHURCH HILL RD CHESTERTOWN, MD 21620

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signeture: D. Spark

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02577

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ETHEL HOSSELRODE
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 18:04
4a. Facility Name (If not institution, give street and number): LIONS MANOR NURSING HOME
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-05-4135
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 1 1915
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: LAVALE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17 NORTH WOODLAWN AVENUE
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): FREDERICK ALVERY GATES
18. Mother's Name (First, Middle, Maiden Surname): NAOMI CATHERINE BUCY

19a. Informant's Name/Relationship (Type, Print): ROBERTA ANN LEWIS
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): DAUGHTER 10808 WASHINGTON HOLLOW ROAD FROSTBURG, MARYLAND 21532

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HILLCREST CEMETERY
Date: JAN 23 2001
20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Cardiorespiratory Failure — approx. 5hr

Due to (or as a consequence of):
b. Arteriosclerotic Cardiovascular disease 15 yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wayne C Spiggle MD
29c. License number: D11443
29d. Date signed (Month, Day, Year): January 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wayne C. Spiggle MD, Braddock Medical Group, 912 Seton Drive, Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Penny G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Mary E Hosselrode

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

Mrs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02578

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS MICHAEL HARDINGER SR.
2. Date of Death (Month, Day, Year): JANUARY 21 2001
3. Time of Death: 4:46 PM
4a. Facility Name (If not institution, give street and number): 12516 BEECHVIEW DRIVE
4b. City, Town, or Location of Death: CORRIGANVILLE
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217-28-9223
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 18 1932
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CORRIGANVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12516 BEECHVIEW DRIVE
10f. Zip Code: 21524
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-1955
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): KELLY SPRINGFIELD TIRE CO.
16b. Kind of Business/Industry: MANUF. TIRES

17. Father's Name (First, Middle, Last): JAMES WILLIAM HARDINGER
18. Mother's Name (First, Middle, Maiden Surname): ROSALIE KEEFER

19a. Informant's Name/Relationship (Type, Print): IMOGENE HARDINGER WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12516 BEECHVIEW DRIVE CORRIGANVILLE MD. 21524

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): REST LAWN CEMETERY
Date: JAN 24 2001
20c. Location - City or Town, State: LAVALE MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic lung Cancer — 4 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Thrombocytosis, Anemia, Hyponatremia Seizure disorder

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Husam Semaan, M.D.
29c. License number: D 0056207
29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR HUSAM SEMAAN 925 BISHOP WALSH ROAD CUMBERLAND MARYLAND 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: Penny B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02579

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn F. Hare

2. Date of Death: Month: January; Day: 22; Year: 2001

3. Time of Death: 22:00

4a. Facility Name (If not institution, give street and number): Lions Manor Nursing Home

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-05-7440

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 4, 1915

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: LaVale

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1125 Braddock Road

10f. Zip Code: 21502

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Joseph L. Biggs

18. Mother's Name (First, Middle, Maiden Surname): Josephine (Green)

19a. Informant's Name/Relationship (Type, Print): James Hare

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4601 Smokey Wreath Way; Ellicott City MD 21043

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hillcrest Memorial Par

Date: 1/25/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Bilateral pneumonia — 10days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Carcinoma of the uterus. C.A.D, C.H.F, dehydration. dysphagia.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V. A. Ranjithan

29c. License number: D19750

29d. Date signed (Month, Day, Year): January 24, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V.A. Ranjithan MD, Lions Manor Nursing Home, Seton Drive Extended, Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 25 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Evelyn F Hare

6

MS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02580

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALICE ROMAINE HAWKINS

2. Date of Death (Month, Day, Year): Jan. 16, 2001

3. Time of Death: 2:50PM

4a. Facility Name *(If not institution, give street and number)*: Civista Medical Center

4b. City, Town, or Location of Death: LaPlata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 219-78-8257

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG. 9, 1945

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: INDIAN HEAD

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: #1 OAKSIDE LANE

10f. Zip Code: 20640

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 9th

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: UNKNOWN

18. Mother's Name *(First, Middle, Maiden Surname)*: CATHERINE ELIZABETH HAWKINS

19a. Informant's Name/Relationship *(Type, Print)*: SHARON HAWKINS-DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: SAME AS #10

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: ST. PETERS CEMETERY

Date: 1-22-01

20c. Location - City or Town, State: WALDORF, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Michael O. Raymond M00479

22. Name and Address of Facility: RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Sepsis

Due to (or as a consequence of): Renal failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of): Diabetes

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D-0045737

29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nimaladevi Gurusamy, M.D. 6 Post Office Road Suite 103 Waldorf, MD 20602

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Allie Hawkins
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CHAR/25

TB

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #19B PER F.H. G793 3-1-01 WR.

Certificate of Death

Reg. No. 2001 02581

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dolores Atienza Horwath

2. Date of Death (Month, Day, Year): JANUARY 3, 2001

3. Time of Death: 1646

4a. Facility Name (If not institution, give street and number): 9810 BINYON COURT

4b. City, Town, or Location of Death: FORT WASHINGTON

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-36-9007

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 7, 1923

9. Birthplace (State or Foreign Country): Philippine Is.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9810 Binyon Court

10f. Zip Code: 20744

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Filipino

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supply Officer

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Nemencio Atienza

18. Mother's Name (First, Middle, Maiden Surname): Leonora Luna

19a. Informant's Name/Relationship (Type, Print): Joseph Horwath/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9810 BINYON CT. FT. WASHINGTON, MD 20744 ~~Same as item 10~~

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metropolitan Crematory

Date: 1/6/2001

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Geo P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Renal Insufficiency

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Salvador Sylvester DO

29c. License number: HO 055927

29d. Date signed (Month, Day, Year): JANUARY 4, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): SALVADOR SYLVESTER DO 7501 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Regina P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02582

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: LUCY BELLE HOUSE

2. Dete of Deeth — Month: JAN. Dey: 9, Year: 2001

3. Time of Deeth: 3:00 AM

4e. Feciiity Neme *(If not institution, give street end number)*: BEVERLY HEALTH CARE CENTER OF HAGERSTOWN

4b. City, Town, or Location of Deeth: HAGERSTOWN

4c. County of Deeth: WASHINGTON

Funeral Director

5. Social Security Number: 216-22-9344

6. Sex: 1☐M 2☒F

7. Age *(In yrs. lest birthday)*: 98 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: 12/2/1902

9. Birthpiece *(Stete or Foreign Country)*: PENNSYLVANIA

To Be Completed by Funeral Director

Usuel Residence of Decedent

10e. State: WV

10b. County: BERKELEY

10c. City, Town or Location: INWOOD

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 2011 SULPHER SPRINGS RD.

10f. Zip Code: 25428

10g. Citizen of Whet Country?: USA

11. Meritei Status: 1☐Never Merried 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - Americen Indien, Bieck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 0; College (1-4or 5+):

16e. Decedent's Usuei Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Fether's Neme *(First, Middle, Last)*: CHARLES SWOPE

18. Mother's Neme *(First, Middle, Meiden Surneme)*: RACHEL CARBAUGH

19e. Informent's Neme/Reietionship *(Type, Print)*: MARIE ORSINI/GREAT NIECE

19b. Meiling Address *(Street end Number or Ruret Route Number, City or Town, Stete, Zip Code)*: 2011 SULPHUR SPRINGS RD., INWOOD, WV 25428

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, cremetory or other piece)*: REFORMED CEMETERY

Date: 1/12/01

20c. Location - City or Town, Stete: SHEPHERDSTOWN, WV

21. Signeture of Funeral Service Licensee: Charles M. Brown

22. Neme end Address of Feciiity: BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feiiure. List only one ceuse on eech line.

Approximete Intervei Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth) e. Chronic Atrial Fibrillation

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. Arteriosclerotic cardiovascular disease

Due to (or es e consequence of):

c. Peripheral vascular disease with

Due to (or es e consequence of):

d. developing gangrene on lower extremities

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

Chronic obstructive lung disease

Congestive heart failure

Aortic stenosis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☑Probably 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings aveiiebie prior to completion of cause of death? 1☐Yes 2☑No

25. Wes case referred to medicai exeminer? 1☐Yes 2☑No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA; Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☑Neturei 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑**Certifying Phyeiciee:** To the best of my knowiedge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es steted. 2☐**Medicel Exeminer:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred at the time, dete end piace, end due to the cause(s) end manner stated.

29b. Signeture end title of certifier: M.D.

29c. License number: D0041131

29d. Dete signed *(Month, Dey, Yeer)*: Jan. 9, 2001

30. Neme end eddress of person who compieted cause of deeth (Item 23e) (Type, Print): JERRY L. COPPEDGE, M.D. 750 Dual Highway Hagerstown, MD 21740

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 16 2001

32. Registrer's Signeture: Pamela B Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEM: #8 PER F.H. G794 4-2-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02583

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): SHIRLEY ANN JOHNSON
2. Date of Death Month: January Day: 12 Year: 2001
3. Time of Death: 1430
4a. Facility Neme (If not institution, give street end number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 213-70-9616
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthdey): 44 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): 5-28-56 (1956)
9. Birthplace (State or Foreign Country): MD.

Usuel Residence of Decedent

10a. State: MD.
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 515-ROBINSON STREET
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Biack, White, etc. Specify: BLACK

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): GRADER
16b. Kind of Businass/Industry: TYSON FOOD'S

17. Father's Nema (First, Middle, Last): HERBERT SPENCE
18. Mother's Neme (First, Middle, Maidan Surname): ETHEL ATKINS SPENCE

19a. Informant's Neme/Reletionship (Type, Print): MELVIN JOHNSON - HUSBAND
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 515-ROBINSON STREET, SALISBURY, MD. 21801

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other piece): MT. CALVARY CEMETARY
Dete: 1/20/2001
20c. Location - City or Town, Stete: NEWARK, MD.

21. Signetura of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert teilure. List only one causa on aach lina. — Approximate Interval Between Onset end Deeth

Immediete Cause (Finat disease or condition resulting in deeth)
a. Ventricular Asystole — min
Due to (or es a consequence of):
b. Hypoxic encephalopathy — hr
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese raterred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signeture and title of certifier: [signature]
29c. License number: D20441
29d. Date signed (Month, Day, Year): January 14, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph L. Raffetto, M.D. 400 Eastern Shore Dr., Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signeture: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02584

Amend #15, 16a, 16b, 1/12/2001, BMW, Montg. Co.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Archie Lee James

2. Date of Death (Month, Day, Year): JANUARY 8 2001

3. Time of Death: 10:59 A.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 229-36-5216

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 20, 1932

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2 Salix Court

10f. Zip Code: 21220

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ~~(Unk)~~ 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Engineer

16b. Kind of Business/Industry: Industrial ~~Engineering~~

17. Father's Name (First, Middle, Last): Henry Jackson James

18. Mother's Name (First, Middle, Maiden Surname): Mary Elizabeth Hodge

19a. Informant's Name/Relationship (Type, Print): Faye Ficarro / Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Salix Court., Baltimore, MD 21220

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Park

Date: 1/12/01

20c. Location - City or Town, State: Glen Burnie, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann

22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CAD CORONARY ARTERY DISEASE

Due to (or as a consequence of):
b. HTN HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Aspiration ASPIRATION

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D47658

29d. Data signed (Month, Day, Year): JANUARY 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KILMARCE KASHI, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

JAMES, ARCHIE

Mont

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #2,01/24/01,T.M., Kent Co.

Certificate of Death

Reg. No. 2001 02585

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Lewis Klingman
2. Date of Death Month: January Day: 15 Year: 2001
3. Time of Death: 2 04pm
4a. Facility Name (If not institution, give street and number): Corscia Hills Nursing Home
4b. City, Town, or Location of Death: Centreville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 300-12-9652
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 8, 1919
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Millington
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 309 Rings End Rd.
10f. Zip Code: 21651
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1 ☒ Yes 2 ☐ No — If Yes, Give Yaar or Datas: 1942 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 ☐ Yes 2 ☒ No Specify:
14. Raca - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line
16b. Kind of Business/Industry: Automobile
17. Father's Name (First, Middle, Last): Louis Klingman
18. Mother's Name (First, Middle, Maiden Surnema): Mamie Brown
19a. Informant's Name/Retationship (Type, Print): Margaret E. Klingman
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 309 Rings End Rd. Millington, Md. 21651
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify)
20b. Placa of Disposition (Name of cametery, cremetory or other place): Sudlersville Cemetery
Date: 1-18-01
20c. Location - City or Town, State: Sudlersville, MD.
21. Signature of Funeral Service Licensee: Gary B Fellows M
22. Name and Address of Facility: Fellows Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington, Md. 21651

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon.**

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that caused the death. Do not enter tha mode of dyirtg, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediata Causa (Final disease or condition resulting in death)
a. Lung Cancer — 6 M
Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were eutopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Was case rafarred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and ptaca, and due to the cause(s) end menner steted.

29b. Signature and title of certifier: G J Sprouse
29c. Licensa number: D32036
29d. Date signed (Month, Day, Year): 1/16/2001

30. Name and addess of person who completed cause of death (Item 23a) (Type, Print): Gary J Sprose 2108 D. Dutch Drive Chester, MD 21619

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02586

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kathryn Ford Kaufman
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 1:05 p.m.
4a. Facility Name (If not institution, give street and number): Corsica Hill Nursing Home
4b. City, Town, or Location of Death: Centreville
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 219-01-2125
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): October 17, 1916
9. Birthplace (State or Foreign Country): Still Pond, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Betterton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13975 Still Pond Road
10f. Zip Code: 21610
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner/Operator
16b. Kind of Business/Industry: Restuarant/Inn

17. Father's Name (First, Middle, Last): Wallace Herman Ford
18. Mother's Name (First, Middle, Maiden Surname): Helen Hackett

19a. Informant's Name/Relationship (Type, Print): Allan Moore
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13989 Still Pond Road, Still Pond, MD 21667

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Still Pond Cemetery
Date: 1/26/2001
20c. Location - City or Town, State: Still Pond, MD

21. Signature of Funeral Service Licensee: ▶ Kirk J. Helfenbein
22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Ischemic cardiomyopathy	3M
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ G. Hawes
29c. License number: D32036
29d. Date signed (Month, Day, Year): 1/22/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Gary T. Hawes 2108 S. Bond Drive Chester, MD 21619

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: D. Hawes

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02587

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph John Keating
2. Data of Death Month Day Year: January 17, 2001
3. Time of Death: 11:00 AM
4a. Facility Name *(If not institution, give street and number)*: 87 Mount Pleasant Street
4b. City, Town, or Location of Death: Frostburg
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-05-9775
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: 05-Dec-12
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Frostburg
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 87 Mount Pleasant Street
10f. Zip Code: 21532-
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Giva Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1 [ ] Yas 2 [X] No *Specify:*
14. Raca - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — Collega (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: police sergeant
16b. Kind of Business/Industry: state government

17. Fathar's Nama *(First, Middla, Last)*: John W. Keating
18. Mothar's Nama *(First, Middle, Maiden Sumama)*: Mary Ellen Winner

19a. Informant's Name/Relationship *(Type, Print)*: Mary Louise Keating wife
19b. Mailing Address *(Straat and Number or Rurel Routa Number, City or Town, Stata, Zip Code)*: 87 Mount Pleasant Stre Frostburg Maryland 21532-

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetary, cramatory or othar placa)*: Saint Michael's Parish Cemetery
Data: 20-Jan-01
20c. Location - City or Town, State: Frostburg, Maryland

21. Signatura of Funaral Service Licensee: John R Durst
22. Nama and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications thet causad tha daath. Do not antar tha *mode* of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List *only one* causa on aach lina.

Approximata Interval Batwaen Onsat and Death

Immediate Causa (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 1 day
Due to (or as a consequence of):
b. Coronary Artery Disease — 15 years.

Sequentially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaase or Injury that initiated evants resulting in death) Last
Due to (or as a consaquanca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: Organic Brain Syndrome

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Were autopsy findings available prior to complation of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case rafarred to medical examinar? 1 [ ] Yas 2 [X] No

26. Piece of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [X] Residence 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Dascribe how injury occurred
28a. Placa of Injury - At homa, farm, straet, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurred at tha time, date and placa, and due to the causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the causa(s) and mannar stated.

29b. Signatura and title of certifier: Jesus
29c. Licanse number: D21244
29d. Data signed *(Month, Day, Year)*: 1/18/01

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Jesus Tan, M.D., Frostburg Plaza, Frostburg, Maryland 21532

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signatura: Bonnie D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

8

MS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02588

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARLENE NELLIE KETTERMAN

2. Date of Death Month Day Year: January 22 2001

3. Time of Death: 7:20 AM

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-28-9334

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 27 1933

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 306 EAST INDUSTRIAL BLVD.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOME MAKER

16b. Kind of Business/Industry: HOME MAKER

17. Father's Name *(First, Middle, Last)*: THOMAS BOYD WHETZEL

18. Mother's Name *(First, Middle, Maiden Surname)*: NELLIE LEONA WHETZEL

19a. Informant's Name/Relationship *(Type, Print)*: JAMES F. KETTERMAN HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 306 E. INDUSTRIAL BLVD. CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: REST LAWN CEMETERY

Date: JAN 24 2001

20c. Location - City or Town, State: LAVALE MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPOXIA — UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC PANCREATIC CANCER — UNKNOWN

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christine Lewis

29c. License number: D54630

29d. Date signed *(Month, Day, Year)*: JAN/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHRISTINE P. LEWIS MD 224 WASHINGTON ST. CUMBERLAND MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: Barbara G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

MLS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #19B PERF.H. G792 2-28-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02589

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Klebanoff
2. Date of Death (Month, Day, Year): January 1, 2001
3. Time of Death: 12:35PM
4a. Facility Name (If not institution, give street and number): Fort Washington Hospital
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 100-20-2106
6. Sex: 1☒ M 2☐ F
7. Age (in yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug.21,1928
9. Birthplace (State or Foreign Country): New York, N.Y.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10831 Hill Top Drive
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1946-1948
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Aide Glass Blower/Physical Science
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Gregory Klebanoff
18. Mother's Name (First, Middle, Maiden Surname): Mary Kutch

19a. Informant's Name/Relationship (Type, Print): Nancy A. Klebanoff/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): ~~Same as item 10~~ 10831 HILL TOP DR. FT. WASHINGTON MD. 20744

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory
Date: 1/3/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ George P. Kalas, Jr.
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the *time*, date and place, end due to the cause(s) and *manner* as stated. 2☐ **Medical Examiner:** On the basis of *examination* and/or Investigation, in *my* opinion, death occurred at the *time*, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D-18545
29d. Date signed (Month, Day, Year): JANUARY 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): P. WISOTSKY MD 12070 OLD LINE COURT WALDORF, Md. 20602

State Registrar

31. Date filed (Month, Day, Year): JAN 03 2001
32. Registrar's Signature: Gregory P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02590

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA MAE MASON
2. Date of Death (Month, Day, Year): JAN. 14 2001
3. Time of Death: 1455
4a. Facility Name (If not institution, give street and number): CORSICA HILLS NURSING HOME
4b. City, Town, or Location of Death: CENTREVILLE
4c. County of Death: QUEEN ANNE'S

Funeral Director

5. Social Security Number: 215-16-3048
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 20, 1911
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: QUEEN ANNE'S
10c. City, Town or Location: CHESTERTOWN
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 2036 PONDTOWN ROAD
10f. Zip Code: 21620
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC WORKER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): JEROME BRATCHER
18. Mother's Name (First, Middle, Maiden Surname): ANNIE BROOKS

19a. Informant's Name/Relationship (Type, Print): VIRGINIA CAIN
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33206 CYPRESS RD., MILLINGTON, MD 21651

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MT. PLEASANT CEMETERY
Date: 1-18-2001
20c. Location - City or Town, State: PONDTOWN, MD

21. Signature of Funeral Service Licensee: Gary B Fellows
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 370 CYPRESS ST., MILLINGTON, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Leaking dissection of the aorta — 2 weeks
Due to (or as a consequence of):
b. uncontrolled hypertension
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
left thalmic hemorrhage
left cerebrovascular accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: M.D.
29c. License number: D0054780
29d. Date signed (Month, Day, Year): 01/15/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marisa Frisella M.D. 122 Speer Road, Chestertown, MD 21620

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Denise B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02591

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
CLAUDE ROLF MANLEY	Jan. 22, 2001	4:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Civista Medical Center	La Plata	Charles

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-90-4875	1☒M 2☐F	37 Yrs.			June 17, 1963	Oklahoma

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Charles	Waldorf	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4006 Bluebird Drive	20603	USA

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Disabled	

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Claude Edward Manley	Kerstin Inga-Lisa Sund Manley

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kerstin Manley/Mother	4418 78 Old Sunbeam Dr. South Daytona, FL. 32119-

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Brinsfield-Echols FH	1/24/01	Charlotte Hall, MD

21. Signature of Funeral Service Licensee		22. Name and Address of Facility
David C. Echols	M00945	AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in death)	a. HEMORRHAGIC SHOCK	
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	b. GASTROINTESTINAL BLEED	
	Due to (or es a consequence of):	
	c. CIRRHOSIS OF LIVER	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.

COAGULOPATHY

THROMBOCYTOPENIA

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.
2☐**Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	D-53885	1/22/2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

Venkat S. Ramanan, MD 6 Post Office Road, Suite 101, Waldorf, Maryland 20602

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 23 2001	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Claude Manley

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02592

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EMORY W. MERRBACH
2. Date of Death Month / Day / Year: JANUARY 21, 2001
3. Time of Death: 14:35
4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 218-16-3832
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: SEPTEMBER 30, 1923
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FROSTBURG
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 10932 GREEN ROW ROAD N.W.
10f. Zip Code: 21532
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER
16b. Kind of Business/Industry: REFRACTORY

17. Father's Name *(First, Middle, Last)*: EMORY MERRBACH
18. Mother's Name *(First, Middle, Maiden Surname)*: LULA RANKIN

19a. Informant's Name/Relationship *(Type, Print)*: ANNA MERRBACH / WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10932 GREEN ROW ROAD N.W. FROSTBURG, MD 21532

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: CUMBERLAND CREMATORY
Date: JANUARY 22, 2001
20c. Location - City or Town, State: CUMBERLAND, MARYLAND

21. Signature of Funeral Service Licensee: John R. Durst
22. Name and Address of Facility: DURST FUNERAL HOME P.A. 57 FROST AVENUE FROSTBURG, MD. 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. PULMONARY HEMORRHAGE — 2 HOURS.

Due to (or as a consequence of):
b. LUNG CARCINOMA — UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE
Ischemic (R) Lower Extremity from Peripheral Vascular Disease
ACUTE Myocardial Infarction.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Changnon D.
29c. License number: D25638
29d. Date signed *(Month, Day, Year)*: JANUARY 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SATURNINA CHANGNON M.D. 10701 New Georges Creek S.W. Suite 3 Frostburg Maryland 21532

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02593

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Harold Morgan, Jr.

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 1600

4a. Facility Name (If not Institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 410-42-1739

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 4, 1930

9. Birthplace (State or Foreign Country): Tennessee

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: Indian Head

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 27 Glymont Rd.

10f. Zip Code: 20640

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1951-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): William H. Morgan, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Katherine Rose McGovern

19a. Informant's Name/Relationship (Type, Print): Mae Morgan Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Charles Cemetery

Date: January 18, 2001

20c. Location - City or Town, State: Indian Head, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Williams Funeral Home, P.A. 4270 Hawthorne Rd., Indian Head, Md. 20640

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Stroke

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Salvador Sylvester, DO

29c. License number: MD0 55927

29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02594

Physician /Medical Examiner | **Funeral Director**

1. Decedent's Name (First, Middle, Last): Sophie Metz

2. Date of Death — Month: Jan. Dey: 2, Yeer: 2001

3. Time of Death: 4:14 pm

4a. Facility Name (If not institution, give street and number): Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

5. Social Security Number: 094-24-8570

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Yaar — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Date of Birth (Month, Dey, Yeer): Feb. 11, 1927

9. Birthplece (State or Foraign Country): Germany

Usuel Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 3485 South Leisure World Blvd.

10f. Zip Coda: 20906

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grede completed) — Elemantery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa ratired): Homemaker

16b. Kind of Businass/Industry: Home

17. Fether's Neme (First, Middle, Last): Ludwig Koelsch

18. Mother's Neme (First, Middle, Maiden Surname): Frieda Ulmer

19a. Informant's Name/Reletionship (Type, Print): Robert Metz/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3485 S Leisure World Blvd, Silver Spring, MD 20906

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): MD Veterans Cemetery

Deta: Jan 5 2001

20c. Location - Clty or Town, Stete: Crownsville, MD

21. Signature of Funeral Service Licensee: James E. Barranco

22. Name end Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the diseases or complications thet caused the deeth. Do not antar the mode of dying, such es cardiac or respiratory errast, shock, or heert feilure. List only one cause on eech line.

Approximata Interval Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. Acute Intraabdomenal Bleed — 13 hours

Dua to (or as a consequance of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disaese or injury that initieted evants resulting in death) Lest

b.

Due to (or as e consequence of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause given in Part I.

Cardiac Arrest

Perforated Viscous

Widely Metastatic Lung cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yas 2☐ No

26. Place of Death (Check only one) — Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Mannar of Death: 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Piece of Injury - At homa, ferm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Dete of Injury (Month, Dey Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one) — 1☐ **Certifying Physician:** To the best of my knowledga, deeth occurred et the time, date end plece, end due to tha cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end plece, and due to tha cause(s) and mennar statad.

29b. Signature and title of certifier: Arthur F. Woodward JR MD

29c. Licensa number: D24190

29d. Date signed (Month, Day, Year): January 3, 2001

30. Neme and eddress of person who completed causa of daath (Item 23a) (Type, Print): ARTHUR F Woodward JR 3416 Olandwood Court Olney Maryland 20832

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 04 2001

32. Registrer's Signeture:

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

A.A.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02595

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Selena Reynolds Mackie
2. Date of Death: Month January, Day 7, Year 2001
3. Time of Death: 1656 P
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 222-16-1879
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 30, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 402 Maryland Avenue
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): John E. Reynolds
18. Mother's Name (First, Middle, Maiden Surname): Lillian Graves

19a. Informant's Name/Relationship (Type, Print): Michael Mackie/Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 176 Thankless Lane, Rising Sun, Maryland 21911

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gilpin Manor Memorial Park
Date: 1/10/01
20c. Location - City or Town, State: Elkton, Maryland

21. Signature of Funeral Service Licensee: John E. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIORESPIRATORY ARREST
Due to (or as a consequence of): b. ISCHEMIC BOWEL
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. SMALL BOWEL OBSTRUCTION
Due to (or as a consequence of): d. ADHESIONS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HYPOCALCEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Denitzio
29c. License number: D30291
29d. Date signed (Month, Day, Year): January 9, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Denitzio, M.D., 111 West High Street, Elkton, Maryland 21921

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

24

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #1 PER PHY G794 4/2/01 WR. *Certificate of Death* Reg. No. 2001 02596

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~Carvis William Opher~~ CARVIS WILLIAM OPHER
2. Date of Death — Month: January Day: 04 Year: 2001
3. Time of Death: 1102am
4a. Facility Name (If not institution, give street and number): Dorchester General Hospital
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 216-18-2091
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): February 27, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 700 Stiles Circle
10f. Zip Code: 21613
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: 1943-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: Publishing

17. Father's Name (First, Middle, Last): Alfred Opher
18. Mother's Name (First, Middle, Maiden Surname): Minnie Dixon

19a. Informant's Name/Relationship (Type, Print): Lillian Opher
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Stiles Circle Cambridge, Maryland 21613

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Veterans Cemetery
Date: 1/09/2001
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: ▶ Janelle C. Henry
22. Name and Address of Facility: HENRY Funeral Home P.A. 510 Washington St. Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiac Arrhythmia — 4mins

Due to (or as a consequence of):
b. Coronary Heart Disease — 5yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Michael Fadden MD
29c. License number: D26388
29d. Date signed (Month, Day, Year): JAN 06, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Fadden MD 302 Collins Hurlock Md 21643

State Registrar

31. Date filed (Month, Day, Year): JAN 0 9 2001
32. Registrar's Signature: ▶ Denise G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02597

NAME: OEHRING, MADELINE ESTELLA

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, WASHINGTON

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name (First, Middle, Last): Madeline Estella OEHRING				2. Date of Death Month Day Year: JANUARY 01, 2001	3. Time of Death: 8:24 AM
4a. Facility Name (If not institution, give street and number): Reeders Memorial Home	4b. City, Town, or Location of Death: Boonsboro	4c. County of Death: Washington			
5. Social Security Number: 220-16-1264	6. Sex: 1☐ M 2☒ F	7. Age (In yrs. last birthday): 75 Yrs.	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year): July 2, 1925
9. Birthplace (State or Foreign Country): Maryland					
Usual Residence of Decedent					
10a. State: Maryland	10b. County: Washington	10c. City, Town or Location: Hagerstown			10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11405 Lakeside Drive	10f. Zip Code: 21740	10g. Citizen of What Country?: U.S.A.			
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:	14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 11 College (1-4or 5+): 0	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk	16b. Kind of Business/Industry: Aircraft			
17. Father's Name (First, Middle, Last): David Horn	18. Mother's Name (First, Middle, Meiden Surneme): Helen G. Weaver				
19a. Informant's Name/Relationship (Type, Print): Marie Russell - Sister	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 22534 Jefferson Blvd. Smithsburg, Md. 21783				
20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Other (Specify)	20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Cedar Lawn Memorial Park	Dete: 1/4/01	20c. Location - City or Town, Stata: Hagerstown, Maryland		
21. Signature of Funeral Service Licensee: Scott M Minnich	22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740				

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

23a. Part1. Enter the disease, or complications thet ceused tha death. Do not entar tha moda of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Cerebral vascular accident — 6 wks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebrovascular Accident with left hemiparesis
Hypertensive cardiovascular disease Hypothyroidism
Osteoarthritis Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred et the time, date and piace, and due to the cause(s) and manner steted.

29b. Signetura and title of certifier: DATTA MD

29c. License number: D18019

29d. Data signed (Month, Dey, Year): JAN 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR VASANT DATTA 334 MILL STREET HAGERSTOWN, MARYLAND 21740/ 301-739-7100

State Registrar

31. Dete filed (Month, Day, Year): JAN 03 2001

32. Registrer's Signature

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02598

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RYAN PATRICK O'STEEN
2. Date of Death: Month January Day 5 Year 2001
3. Time of Death: 3:50 p.m.
4a. Facility Name (If not institution, give street and number): 9745 Smith Way
4b. City, Town, or Location of Death: Dunkirk
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 217 08 2614
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 17 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Dec. 25, 1983
9. Birthplaca (State or Foraign Country): Baltimore, MD

Usual Residenca of Decedant

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Dunkirk
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9745 Smith Way
10f. Zip Coda: 20754
10g. Citizan of What Country?: USA

11. Marital Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: white

15. Decedent's Education (Specify only highast grada complatad): Elamantary/Secondary (0-12): 12 | Collaga (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired): student
16b. Kind of Businass/Industry: high school

17. Fathar's Nama (First, Middla, Last): Lawrence Charles O'Steen
18. Mothar's Nama (First, Middla, Maidan Surnama): Eileen Marie O'Malley

19a. Informant's Name/Ralationship (Type, Print): Lawrence C. O'Steen / father
19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code): same as # 10 above

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Metropolitan Crematory
Data: 01-08-01
20c. Location - City or Town, Stata: Alexandria, VA

21. Signatura of Funaral Sarvica Licensee: William R. [illegible]
22. Nama and Addrass of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart tailura. List only one causa on aach lina.

Approximata Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death)
a. Acute Respiratory Failure
Dua to (or as a consaquanca of):
b. San Phillipo Syndrome — Congenital
Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Last
Dua to (or as a consaquanca of):
c.
Dua to (or as a consaquanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ Certifying Physician: To tha best of my knowledga, death occurrad at tha tima, data and placa, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and due to the cause(s) and mannar stated.
29b. Signatura and title of certifier: [signature]
29c. Licansa number: D 33123
29d. Data signed (Month, Day, Year): 1-6-01

30. Nama and addrass of parson who complatad causa of daath (Item 23a) (Type, Print): Jonathan Lowenthal, MD Dunkirk, MD 20754

State Registrar

31. Data filed (Month, Day, Year): JAN 1 0 2001
32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requiras that the death certificate be axacutad within 24 hours after death.
To the Funaral Director: After this certificate has been signed by the attending physician and completaly filled in by the funaral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-0380-015

STELLA PISPITSOS

ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEMS: # 23 PART I, II, 27, 27, 28A-F PER MEO G794 4-5-01 WR.

Certificate of Death

Reg. No. 2001 02599

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): STELLA MARIE PISPITSOS

2. Date of Death: Month JANUARY Day 23 Year 2001

3. Time of Death: 0416

4a. Facility Name (If not institution, give street and number): UNION HOSPITAL

4b. City, Town, or Location of Death: ELKTON

4c. County of Death: CECIL

5. Social Security Number: 222-34-5499

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): SEPT 8, 1947

9. Birthplace (State or Foreign Country): Colorado

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 245 East High Street, Apartment B

10f. Zip Code: 21921

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Legal Assistant

16b. Kind of Business/Industry: City Government

17. Father's Name (First, Middle, Last): Stelios Demetriades

18. Mother's Name (First, Middle, Maiden Surname): Maria

19a. Informant's Name/Relationship (Type, Print): Demetrios Pispitsos/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 436 Buttonwoods Road, Elkton, Maryland 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Immaculate Conception Cemetery

Date: 1/27/01

20c. Location - City or Town, State: Cherry Hill, Maryland

21. Signature of Funeral Service Licensee: Donald E. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPOXIC ISCHEMIC ENCEPHALOPATHY AS A COMPLICATION OF PHENOBARBITAL AND PHENYTOIN OVERDOSE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SEZURE DISORDER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): FOUND: 1-14-01

28b. Time of Injury: FOUND: UNKNOWN M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: SUBJECT TOOK AN OVERDOSE OF DRUGS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND: RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State): 229 E. HIGH ST. ELKTON, MARYLAND

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. Licensa number: O.C.M.E

29d. Data signed (Month, Day, Year): JANUARY 24, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month) Day, Year): FEB 0 1 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02600

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cecil Clemith Pierce, Jr.

2. Date of Death: Month January Day 20 Year 2001

3. Time of Death: 1200

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 197-09-3527

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR 13, 1915

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: North East

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 146 Wheatley Road

10f. Zip Code: 21901

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Dairy

17. Father's Name (First, Middle, Last): Cecil C. Pierce, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Alice Owens

19a. Informant's Name/Relationship (Type, Print): Dorothy G. Pierce/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 146 Wheatley Road, North East, Maryland 21901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Gracelawn Memorial Park

Date: 1/23/01

20c. Location - City or Town, State: New Castle, Delaware

21. Signature of Funeral Service Licensee: ▶ Donald S. Hicks

22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

RQW

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infaration

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Renal Failure

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d. Cardiomyopathy

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Gloria Simonson

29c. License number: D0056449

29d. Date signed (Month, Day, Year): 01/20/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gloria Simonson, MD 111 West High St. Suite 302 Elkton MD 21921

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State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02601

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carol Chadwick Petty
2. Date of Death: Month January Day 18, Year 2001
3. Time of Death: 12:30AM
4a. Facility Name (If not institution, give street and number): 603 William Street
4b. City, Town, or Location of Death: Cambridge
4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 376-30-2088
6. Sex: 1☐ M XX F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 22, 1930
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Cambridge
10d. Inside City Limits: XX Yes 2☐ No
10e. Street and Number: 603 William Street
10f. Zip Code: 21613
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- tt Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 5+
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher
16b. Kind of Business/Industry: Education

17. Fether's Neme (First, Middle, Last): John Russell Chadwick
18. Mother's Name (First, Middle, Maiden Surneme): Helen Moore

19a. Intorment's Neme/Reletionship (Type, Print): Douglas Petty Husband
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 603 William Street Cambridge, Maryland 21613

20a. Method ot Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Salisbury Crematory
Dete: 1/19/01
20c. Location - City or Town, Stete: Salisbury, Maryland

21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address ot Feciity: Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode ot dying, such es cerdiec or respiratory arrest, shock, or heart teilure. List only one ceuse on eech line. (Approximete Interval Between Onset end Deeth)

Immediete Cause (Finel diseese or condition resulting in deeth):
a. LUNG CANCER — 14 mo
Due to (or as e consequence ot):
b.
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Last
Due to (or es e consequence ot):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert t.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No
26. Piece ot Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete ot Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece ot Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner es stated. 2☐ **Medicat Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and menner stated.
29b. Signeture end titie of certifier: [signature] MD
29c. License number: D33622
29d. Date signed (Month, Day, Year): 01-18-01

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): CRAIG W CADWELL, 2 AURORA ST, CAMBRIDGE, MD 21613

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 19 2001
32. Registrar's Signeture: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02602

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ASALIE PAULINE PITTMAN
2. Date of Death: Month JAN Day 13 Year 01
3. Time of Death: 15:30
4a. Facility Name (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 182-22-6983
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEP 28 1912
9. Birthplace (State or Foreign Country): EDNEYVILLE NC

Usual Residence of Decedent

10e. State: PA
10b. County: FRANKLIN
10c. City, Town or Location: MARION
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 102 COLORADO ST.
10f. Zip Code: 17235
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): THOMAS CLINGMAN RHODES
18. Mother's Name (First, Middle, Maidan Surname): MARY MAXWELL

19a. Informant's Name/Relationship (Type, Print): MARILYN SEILHAMER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 39 MARION, PA 17235

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): BROWN'S MILL CEM.
Date: 1/17
20c. Location - City or Town, State: ANTRIM TWP. FRANKLIN CO, PA

21. Signature of Funeral Service Licensee: ▶ James A. Bowersox
22. Name and Address of Facility: MILLER-BOWERSOX FUNERAL HOME 521 S WASHINGTON ST GREENCASTLE PA

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CORONARY OCCLUSION — Sudden
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D0011266
29d. Date signed (Month, Day, Year): JAN 13, 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H.N. Weeks MD Hagerstown MD

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Dr. Keamy-Thompsburg Pa Hospital Certificate

ASALIE P. PITTMAN

01-0277-015
crn
Mary Louise Racine

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02603

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Louise Racine
2. Date of Death: Month January, Day 14, Year 2001
3. Time of Death: 11:17 A.M.
4e. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 211-22-2551
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): July 1, 1930
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Charlestown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 47 Greenspring Road
10f. Zip Code: 21914
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Operator
16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): Mabel (unknown)

19a. Informant's Name/Relationship (Type, Print): Robert Keith Burke / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 223, Charlestown, Maryland 21914

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Edgewood Memorial Park
Date: January 18, 2001
20c. Location - City or Town, State: Glen Mills, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Crouch Funeral Home, 127 South Main Street, North East, Maryland 21901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
e. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? Inspection 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02604

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN WESLEY REYNOLDS

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 0630

4a. Facility Name (If not institution, give street and number): Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221-16-5108

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 4 1916

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: MD

10b. County: Kent

10c. City, Town or Location: Galena

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 591 Mill Lane

10f. Zip Code: 21635

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Harvey G. Reynolds

18. Mother's Name (First, Middle, Maiden Surname): Harriett Carrow

19a. Informant's Name/Relationship (Type, Print): Sylvia Reynolds (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 591 Mill Lane Galena, MD. 21635

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Georges Cemetery

Date: 1/22/01

20c. Location - City or Town, State: St. Georges, DE.

21. Signature of Funeral Service Licensee: M00510

22. Name and Address of Facility: Galena Funeral Home of Stephen Schaech 118 West Cross St. Galena, MD. 21635

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION, PULMONARY EMBOLISM

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. GENERALIZED CARCINOMATOSIS

Due to (or as a consequence of):

d. CARCINOMA RECTUM

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Leo A. Najera MD

29c. License number: D0028644

29d. Date signed (Month, Day, Year): 1-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Leo A. Najera MD 111 W. High St. Elkton, MD. 21921

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02605

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY M. ROSS

2. Date of Death — Month: 01 Day: 15 Year: 2001

3. Time of Death: 4:15 PM

4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital & Medical Center

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-20-5277

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: AUG 6,1925

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14103 PERRYS LANE SW

10f. Zip Code: 21532

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: JOHN WILLIAM SWEITZER

18. Mother's Name *(First, Middle, Maiden Surname)*: HATTIE MAE STOKES

19a. Informant's Name/Relationship *(Type, Print)*: FRANK ROSS - HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14103 PERRYS LANE SW,FROSTBURG,MD 21532

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: REST LAWN MEMORIAL GARDENS

Date: JAN 18,2001

20c. Location - City or Town, State: LAVALE,MD 21502

21. Signature of Funeral Service Licensee: Douglas S Hafer

22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY,LAVALE,MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End stage chronic obstructive pulmonary disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic renal insufficency

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D0040693

29d. Date signed *(Month, Day, Year)*: JANUARY 18 ,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ELIAN, SAMIR A., M.D., 921 SETON DRIVE, SUITE F, CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: Regina D Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

MARY S. ROSS 215-20-5277

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

5

MLS

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02606

Roland Sm. SS# 222-01-4385

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roland B. Smith

2. Date of Death (Month, Day, Year): January 9, 2001

3. Time of Death: 1040

4a. Facility Name (If not Institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 221-01-4385

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1917

9. Birthplace (State or Foreign Country): Wilmington, DE

Usual Residence of Decedent

10a. State: DE

10b. County: Sussex

10c. City, Town or Location: Frankford

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: RD 2 Box 150-328

10f. Zip Code: 19945

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner & Operator

16b. Kind of Business/Industry: Roland B. Smith Upholstery & Awning

17. Father's Name (First, Middle, Last): David W. Smith

18. Mother's Name (First, Middle, Maiden Surname): Ellen Sandstrom

19a. Informent's Name/Relationship (Type, Print): Lois Lathbury (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD 2 Box 577 M Ocean View, DE 19970

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Delaware Veterans Memorial Cemetery

Date: Jan. 12, 2001

20c. Location - City or Town, State: Bear, DE

21. Signature of Funeral Service Licensee: Nicholas R. Perilli

22. Name and Address of Facility: McCrery Funeral Homes, Inc. 3924 Concord Pike Wilm., DE 19803

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Interstitial pulmonary fibrosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic obstructive pulmonary disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D0053394

29d. Date signed (Month, Day, Year): 1/10/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony Frey, M.D. 1315 S. Division St. Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: Geneva B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02607

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francina Stewart
2. Dete of Deeth: Month: January; Day: 17; Year: 2001
3. Time of Deeth: 1003 A
4a. Facility Name *(If not institution, give street and number)*: 32 Muddy Lane
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 211-20-6661
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: July 16, 1909
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 32 Muddy Lane
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondery (0-12): 10; College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Waitress
16b. Kind of Business/Industry: Food Service

17. Father's Name *(First, Middle, Last)*: James Thompson
18. Mother's Neme *(First, Middle, Maiden Surname)*: Clara Thomas

19a. Informent's Neme/Reletionship *(Type, Print)*: George F. Sewell, Sr./Nephew
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 119 Booth Street, Elkton, Maryland 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: Providence Cemetery
Dete: 1/20/01
20c. Location - City or Town, Stete: Elkton, Maryland

21. Signature of Funerel Service Licensee: ▶ Donald S. Hicks
22. Neme end Address of Fecility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List *only one* cause on each line.

Approximete Interval Between Onset end Deeth

Immedete Cause (Final disease or condition resulting in death)
a. Myocard Infarction. — 12 h.
Due to (or as a consequence of):
b. Hypertension — 8 yrs
Due to (or es a consequenca of):
c. Coronary insuffiency
Due to (or es a consequenca of):
d. Hypothyroidism

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medicat examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, fermn, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination end/or Investigation, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶ JUI CHH HSU MD
29c. License number: D04823
29d. Dete signed *(Month, Dey, Year)*: 1/18/01

30. Neme end address of person who completed cause ot deeth (Item 23e) (Type, Print): JUI CHH HSU MD 223 West main st. Cook MD 21921

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 19 2001
32. Registrer's Signeture: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02608

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katherine Stover

2. Data of Death — Month: JANUARY Day: 17 Year: 2001

3. Time of Death: 5:50 A.M.

4a. Facility Name (If not Institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 238-48-4104

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Feb. 21, 1920

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1641 Old Eastern Ave. Apt. C

10f. Zip Code: 21221

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeping

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Robert Richmond

18. Mother's Name (First, Middle, Maiden Surname): Molly Richmond

19a. Informant's Name/Relationship (Type, Print): Frances Maxwell / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1806 Huffine Mill Rd., Greensboro, NC 27405

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Piedmont Cemetery

Date: 1/26/01

20c. Location - City or Town, State: Greensboro, NC

21. Signature of Funeral Service Licensee: ▶ Lisa Scott

22. Name and Address of Facility: Lisa Scott Funeral Home 552 Lewis Street, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 1 DAY

Due to (or as a consequence of):

b. ATRIAL FIBRILLATION — 1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RIGHT HYDROPNEUMOTHORAX

BREAST CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rwende

29c. License number: D56001

29d. Date signed (Month, Day, Year): JANUARY 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CYRIL RUWENDE, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

STOVER, KATHERINE

VS

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #1, 1/26/01, cwc, Kent Co.

Certificate of Death

Reg. No. 2001 02609

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary P. ~~Achman~~ Sears
2. Date of Death: Month January Day 17 Year 2001
3. Time of Death: 3:15 a.m.
4a. Facility Name (If not institution, give street and number): 300 Chino Farms Road
4b. City, Town, or Location of Death: Chestertown
4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 134-36-8878
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 23, 1908
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Queen Anne's
10c. City, Town or Location: Chestertown
10d. Insida City Limits: 1☐ Yaa 2☒ No
10e. Street and Number: 300 Chino Farms Road
10f. Zip Coda: 21620
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Father's Nama (First, Middla, Last): Austin Pouch
18. Mothar's Nama (First, Middla, Maidan Sumama): Julia Achman

19a. Informant's Name/Ralationship (Type, Print): Henry F. Sears
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 841 McGinnis Road, Chestertown, Maryland 21620

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): Family Property
Data: 1/19/2001
20c. Location - City or Town, Stata: Chestertown, MD

21. Signature of Funeral Service Licensee: ▶ Kirk J. Helfenbein
22. Nama and Addrass of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha daath. Do not antar tha mода of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath):
a. MYELODYSPLASTIC DISORDER WITH — >10 yrs.
Dua to (or as a consequanca of): GASTROINTESTINAL BLEEDING

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Dua to (or as a consequanca of):
c. Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.
BREAST CANCER
COLON CANCER
DEMENTIA

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yas 2☒ No

25. Was casa ratarred to medical examinar? 1☐ Yas 2☒ No
26. Placa of Death (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☒ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)
28f. Location (Straat and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of certifier: ▶ Helen A Noble MD
29c. License number: D0041587
29d. Date signed (Month, Day, Year): 1/19/2001

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Helen A. Noble 122 Speer Road, Chestertown, Maryland 21620

State Registrar

31. Data filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signatura: Donna P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

JAN 1 8 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02610

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Lillian Mae Shelton

2. Dete of Death Month Dey Year: January 10, 2001

3. Time of Death: 2148 hrs

4e Facility Neme *(If not Institution, give street end number)*: Corsica Hills Nursing Home

4b. City, Town, or Location of Death: Centreville

4c. County of Death: Queen Anne's

Funeral Director

5. Social Security Number: 222-18-2356

6. Sex: 1☐M 2☒F

7. Age *(In yrs. lest birthday)*: 96 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Yeer)*: August 8, 1904

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10a. Stete: Maryland

10b. County: Queen Anne's

10c. City, Town or Location: Sudlersville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 212 East Main Street

10f. Zip Code: 21668

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐Never Merried 2☐Merried 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Domestic / Own Home

17. Father's Neme *(First, Middle, Last)*: Nathaniel Barrett

18. Mother's Name *(First, Middle, Maiden Surname)*: Ida Mae Bell

19a. Informent's Neme/Reletionship *(Type, Print)*: Norman Barrett

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 111 Stuart Drive, Dover, Delaware 19901

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Sudlersville Cemetery

Dete: January 14, 2001

20c. Location - City or Town, Stete: Sudlersville, Maryland

21. Signetura of Funerel Service Licensee: ▶ William L. King, Jr. M-00937

22. Name end Address of Feciility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 Cypress Street, Maillington, Maryland 21651

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediate Cause (Final diseese or condition resulting in deeth)

a. ADENOCARCINOMA - CECUM — 11/00

Due to (or as a consequance of):

b. MALNUTRITION

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Dementia

23b. Did tobacco use contributa to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☑No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Piece of Death *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☑Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated. 2☐Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶

29c. License number: D0057076

29d. Dete signed *(Month, Day, Year)*: 1/12/01

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): Patricia A. Bowyer MD, MPH 420 Penn Ave, Centreville MD 21617

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 12 2001

32. Registrar's Signeture: ▶ Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02611

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francis J. Schroeder

2. Date of Death — Month: January; Day: 19; Year: 2001

3. Time of Death: 6:45 a.m.

4a. Facility Name *(If not institution, give street and number)*: Cumberland Nursing Home

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 113-03-3269

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 16, 1912

9. Birthplace *(State or Foreign Country)*: NJ

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 132 West Belcrest Road

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 6

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Music Teacher

16b. Kind of Business/Industry: Harford Co. Bd of Ed

17. Father's Name *(First, Middle, Last)*: Henry Frederick Schroeder

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Marron

19a. Informant's Name/Relationship *(Type, Print)*: Dr. Philip J. Schroeder--son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 515 Nemacolin Avenue; Cumberland, MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Heavner Cemetery

Date: 01/27/2001

20c. Location - City or Town, State: Buckhannon, WV

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. for Poling-St. Clair FH Cumberland, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident — 4 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature]

29c. License number: D0033280

29d. Date signed *(Month, Day, Year)*: Jan 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sunil K. Gupta, M.D.; 625 Kent Avenue; Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02612

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Patricia J. Smith
2. Date of Death (Month, Day, Year): January 9, 2001
3. Time of Death: 3:00PM
4a. Facility Name *(If not institution, give street and number)*: 6401 Franklin Gibson Road
4b. City, Town, or Location of Death: Tracy's Landing
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 144-36-5594
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 14, 1946
9. Birthplace *(State or Foreign Country)*: Phil. PA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Tracy's Landing
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6401 Franklin Gibson Road
10f. Zip Code: 20779
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Flight Attendant
16b. Kind of Business/Industry: Airlines

17. Father's Name *(First, Middle, Last)*: William Gorman
18. Mother's Name *(First, Middle, Maiden Surname)*: Yola Blasko

19a. Informant's Name/Relationship *(Type, Print)*: Harry J. Smith/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Same as item 10

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 1/9/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: George P. Kalas, Jr.
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 2973 Solomons Island Road, Edgewater, Md. 21037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Inanition — Months

Due to (or as a consequence of): Metastatic Carcinoma — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones MD
29c. License number: D06054
29d. Date signed *(Month, Day, Year)*: 1/9/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD. 695 America Court Davidsonville, Md. 21035

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 10 2001
32. Registrar's Signature: Jennie B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a, per md G792 2/9/01 yf

Certificate of Death

Reg. No. 2001 02613

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Carmela M. Scarpelli
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 06:40
4a. Facility Name (If not institution, give street and number): Lions Manor Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 212-01-9809
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 30, 1917
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 14218 Clearview Drive SW
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Sewing Factory

17. Father's Name (First, Middle, Last): Nick Scarpelli
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth (Arnone)

19a. Informent's Name/Relationship (Type, Print): John J. Sangiovanni Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 738 Hunt Terrace; Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): St. Michael's Cemetery
Date: 1/10/2001
20c. Location - City or Town, State: Frostburg, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Carmela M Scarpelli
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Electrolyte imbalance — Several days

Due to (or as a consequence of):
b. Renal failure — few weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DIABETIS MELLITUS — 2-3 years

Due to (or as a consequence of):
d. DEHYDRATION — 2-3 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
C.V.A c paraplegia, Hypertensive Cardio-vascular disease, Diabetis Mellitus, Renal failure, abd. aortic aneurysm

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ V. A. Ranjithan
29c. License number: D 19750
29d. Date signed (Month, Day, Year): January 8, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): VA Ranjithan MD, Lions Manor Nursing Home, Seton Drive Extended, Cumberland MD 21502

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

All.

23A

6

State Registrar

31. Date filed (Month, Day, Year): JAN 09 2001
32. Registrar's Signature: ▶ Barbara B Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02614

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Calvin Speis

2. Date of Death: Month 01 Day 2 Year 2001

3. Time of Death: 3:45 p.m.

4a. Facility Name (If not institution, give street and number): 9208 Oswald Way Apt. 1A

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore County

Funeral Director

5. Social Security Number: 579-42-0422

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-26-33

9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore County

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9208 Oswald Way Apt. 1A

10f. Zip Code: 21237

10g. Citizen of What Country? U.S.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber

16b. Kind of Business/Industry: Plumbing

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Maiden Surname): Alma Kriner

19a. Informant's Name/Relationship (Type, Print): Michael L. Speis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9208 Oswald Way Apt. 1A Baltimore, MD 21237

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory Inc

Date: 1-6-2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Janet C. Anderson

22. Name and Address of Facility: Bonnette & Assoc. Funeral Home Inc. 2504 28th St., N.E. Washington, D.C. 20018

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Brain tumor — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier

29c. License number: D18487

29d. Date signed (Month, Day, Year): 1/4/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001

32. Registrar's Signature: Donna P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CR P.G. 10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02615

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maurice Michael Stegmaier

2. Data of Death: Month January Day 03 Year 2001

3. Time of Death: 20:40

4a. Facility Name (If not institution, give street and number): Lions Manor Nursing Home

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-05-8378

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 21, 1910

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 429 N. Centre Street

10f. Zip Code: 21502

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): owner/operator

16b. Kind of Business/Industry: Market

17. Father's Name (First, Middle, Last): Michael L. Stegmaier

18. Mother's Name (First, Middle, Maiden Surname): Sophia (Wagner)

19a. Informant's Name/Relationship (Type, Print): Patty Swartzwelder daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 429 N. Centre Street; Cumberland MD 21502

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Mary's Cemetery

Date: 1/08/2001

20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Electrolyte imbalance — Several weeks

Due to (or as a consequence of):

b. Renal Failure. — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers dementia, Ca of rectum
Severe malnutrition & dehydration
S/P Prostate Ca.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ V. A. Ranjithan

29c. Licensa number: D 19750

29d. Data signed (Month, Day, Year): January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): V.A. Ranjithan, MD, Lions Manor Nursing Home, Seton Drive Extended, Cumberland MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001

32. Registrar's Signature: ▶ Jeanne G Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Maurice Stegmaier

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02616

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William K. Turner
2. Date of Death — Month: January Day: 11 Year: 2001
3. Time of Death: 1715 P
4a. Facility Name *(If not institution, give street and number)*: Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 186-16-3412
8. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 9, 1921
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 22 Bridge View Drive
10f. Zip Code: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: World War II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Worker
16b. Kind of Business/Industry: Automobile Manufacturing

17. Father's Name *(First, Middle, Last)*: Merreall Turner
18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Haws

19a. Informant's Name/Relationship *(Type, Print)*: Linda May Wright/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 22 Bridge View Drive, Elkton, Maryland 21921

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gracelawn Memorial Park
Date: 1/16/01
20c. Location - City or Town, State: New Castle, Delaware

21. Signature of Funeral Service Licensee: Donald S. Hicks
22. Name and Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Overwhelming Sepsis — Days

Due to (or as a consequence of):
b. Central line infection — Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic Obstructive Pulmonary Disease
Ischemic Cardiomyopathy
Diabetes mellitus type II

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*
Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D45155
29d. Date signed *(Month, Day, Year)*: 01/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John Mulvey, M.D., 111 West High Street, Elkton, Maryland 21921

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#7 perFHG796 6/8/01 EW

Certificate of Death

Reg. No. 2001 02617

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Audrey Faye Thomas

2. Date of Death (Month, Dey, Yeer): January 11, 2001

3. Time of Death: 5:30AM

4e. Facility Name (If not institution, give street end number): Mariner Health Care of Greater Laurel

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 217-42-6497

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 ~~56~~ Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): October 9 1943

9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Adelphi

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street end Number: 2012 Quebec Street

10f. Zip Code: 20783

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Eduction (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): Ø

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Laboratory Computer Programmer

16b. Kind of Business/Industry: US Government

17. Fether's Name (First, Middle, Last): Floyd Frantz

18. Mother's Neme (First, Middle, Meiden Surneme): Audrey Friend

19a. Informent's Name/Relationship (Type, Print): Brenda Longest/Daughter

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 14121 Asher View, Centreville, VA 20121

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Grant Cemetery

Dete: 1/13/01

20c. Locetion - City or Town, Stete: Troutdale, VA

21. Signeture of Funeral Service Licensee: ▶ [signature] M00770

22. Neme end Address of Feciility: Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD 20707

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)

e. Hydrocephalus — Years

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dysphagia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: ▶ [signature]

29c. License number: D28998

29d. Dete signed (Month, Day, Yeer): January 11, 2001

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Pritam Saini, MD 9101 Cherry Lane Suite 211, Laurel, MD 20708

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 16 2001

32. Registrer's Signature: ▶ [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ADMEND ITEMS: #1, 2 PER PHY G793 3-6-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02618

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HOWARD J. THOMAS — Howard J. Thomas

2. Date of Death: Month: January; Day: 10; Year: 2001

3. Time of Death: 1613

4a. Facility Name (If not institution, give street and number): UNION HOSPITAL

4b. City, Town, or Location of Death: ELKTON

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 222-16-2422

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 29. 1928

9. Birthplace (State or Foreign Country): Freeman, WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: DE

10b. County: New Castle

10c. City, Town or Location: Wilmington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 203 E. 24th Street

10f. Zip Code: 19801

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Janitor

16b. Kind of Business/Industry: Engineering

17. Father's Name (First, Middle, Last): Edgar Thomas

18. Mother's Name (First, Middle, Maiden Surname): Nannie Sue Turner

19a. Informant's Name/Relationship (Type, Print): Carolyn Thomas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): #2 Second Avenue, Claymont, DE 19703

20a. Method of Disposition: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Haven Mem. Crematory

Date: 1/16/01

20c. Location - City or Town, State: Chester, PA

21. Signature of Funeral Service Licensee: Glenn W. Conn

22. Name and Address of Facility: CONGO Funeral Home 201 N. GRAY AVE, Wilm, De 19805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardio Pulmonary arrest

Due to (or as a consequence of):

b. Chronic Obstructive diseas.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Coronary artery disease

Due to (or as a consequence of):

d. Cerebrovascular accident

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Aspiration pneumonia
Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) ER.

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Sachdev.

29c. License number: D26183

29d. Date signed (Month, Day, Year): 01/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Madhu SACHDEV MD 118 North St, ELKton, md. 21921

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02619

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH C. TAYLOR
2. Date of Death (Month, Day, Year): JAN. 9, 2001
3. Time of Death: 5:00 AM.
4a. Facility Name (If not institution, give street and number): 347 FAIR AVE.
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 212-52-8917
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/29/1912
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 347 FAIR AVE.
10f. Zip Code: 21157
10g. Citizen of What Country? USA.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: HOME MAKER

17. Father's Name (First, Middle, Last): WILLIAM A. CULVER
18. Mother's Name (First, Middle, Maiden Surname): JENNE MAY TAYLOR

19a. Informant's Name/Relationship (Type, Print): HUSBAND WEBSTER J. TAYLOR, SR.
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 347 FAIR AVE., WESTMINSTER, MD. 21157

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) ENTOMBMENT
20b. Place of Disposition (Name of cemetary, crematory or other place): EVERGREEN MEM. GARDENS
Date: 1/12/01
20c. Location - City or Town, State: FINKSBURG, MD.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Esophageal Stricture — 1 YEAR
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] INTERNIST
29c. License number: D 52035
29d. Date signed (Month, Day, Year): Jan 9 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BINU CHACKO 291 Stoney Avenue West minister MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02620

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nancy Kresge Usilton

2. Date of Death: Month Jan. Day 19 Year 2001

3. Time of Death: 5:15 pm

4e. Facility Name (If not institution, give street and number): 24170 Langford Road

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 209-18-8673

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 20 1927

9. Birthplace (State or Foreign Country): Stroudsburg, Pa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Chestertown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 24170 Langford Road

10f. Zip Code: 21620

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 12; College (1-4 or 5+) 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Grover Kresge

18. Mother's Name (First, Middle, Maiden Surname): Helen Singer

19a. Informant's Name/Relationship (Type, Print): Herbert L. Usilton Sr. Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24170 Langford Road Chestertown, Md. 21620

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Cent.

Date: 1/22/01

20c. Location - City or Town, State: Stevensville, Md.

21. Signature of Funeral Service Licensee: Jason Fellows

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home 130 Speer Rd. Chestertown, Md. 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. SUSPECTED ISCHEMIC BOWEL — 2 days

Due to (or as a consequence of):
b. GENERALIZED ATHEROSCLEROSIS — >5 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

SEVERE RHEUMATOID ARTHRITIS
LUMBAR STENOSIS WITH PARAPLEGIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John A Noble MD

29c. License number: D0041587

29d. Date signed (Month, Day, Year): 1/22/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Helen A. Noble, M.D. 122 Speer Rd. Chestertown, Md. 21620

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: [illegible] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend item #26 per physician 01/23/01 m.p. **Certificate of Death** Reg. No. 2001 02621

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK VENDEMIA
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 0650 AM
4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 579-30-3561
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 28, 1927
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Benedict
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 7825 Mill Creek Road
10f. Zip Code: 20612
10g. Citizen of What Country: USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Fabricator
16b. Kind of Business/Industry: Steel/Ironworks

17. Father's Name (First, Middle, Last): Thomas Vendemia
18. Mother's Name (First, Middle, Meiden Surneme): Jessie Dowlan Vendemia

19a. Informant's Name/Relationship (Type, Print): Rosemary P. Vendemia/Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 198 Benedict, MD. 20612

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Resurrection Cemetery | Date: 1/25/01
20c. Location - City or Town, Stete: Clinton, MD.

21. Signature of Funeral Service Licensee: David C. Echols M00945
22. Name and Address of Facility: BRINSFIELD-ECHOLS FUNERAL HOME, P.A. P.O. BOX 128 Charlotte Hall, MD 20622

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Coronary artery Disease
Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c. Post Polyo Syndrome
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contributs to the causs of death? 1 ☐ Yss 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred et the time, date end pleca, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examinar**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D 37588
29d. Date signed (Month, Dey, Yeer): 1-21-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAFIK NASR MD - 135 W. Dares Beach Rd #109 Prince Frederick MD 20678

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 23 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADMEND ITEM: #29C PER D.V.R. G794 4-21-01 WR

Certificate of Death

Reg. No. 2001 02622

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Female Watts - TIMESHA MICHELLE WATTS
2. Date of Death Month / Day / Year: 1 / 7 / 2001
3. Time of Death: 625AM
4a. Facility Name (If not institution, give street and number): Prince Georges Hospital Center
4b. City, Town, or Location of Death: Cheverly, MD 20785
4c. County of Death: P. G.

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours: 2 / Min.:
8. Date of Birth (Month, Day, Year): 1/7/2001
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: LANHAM
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 8409 HAMLIN STREET #303
10f. Zip Code: 20706
10g. Citizen of What Country? U.S.A

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): NONE
College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired): NONE - INFANT
18b. Kind of Business/Industry: NONE - INFANT

17. Father's Name (First, Middle, Last): TIMOTHY HILL
18. Mother's Name (First, Middle, Maiden Surname): TANJA MICHELE WATTS

19a. Informant's Name/Relationship (Type, Print): TANJA M. WATTS / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8409 HAMLIN ST. #303, LANHAM MD 20706

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify) BURIAL
20b. Place of Disposition (Name of cemetery, crematory or other place): PGHC
Date: 1/20/01
20c. Location - City or Town, State: CHEVERLY MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: PGHC 3001 HOSPITAL DR. 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Intarval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Previable gestational age — 2 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaase or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to daath but not resulting in the underiying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa referred to medical examiner? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: P14064
29d. Date signed (Month, Day, Year): 1/2/01

30. Name and address of person who complated causa of death (Item 23a) (Type, Print): PG Hospital Cheverly, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 5, 16a,16b per fh G792 2/9/01 yf

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02623

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Katlyn Michelle Whetzel

2. Date of Death: Month 01 Day 09 Year 01

3. Time of Death: 0340 AM

4e. Facility Name *(If not institution, give street and number)*: Memorial Hospital

4b. City, Town, or Location of Death: Cumberland, MD.

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: none

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min. 58

8. Date of Birth *(Month, Day, Year)*: 01 09 01

9. Birthplace *(State or Foreign Country)*: maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 437 N. Waverly Terrace

10f. Zip Code: 21502

10g. Citizen of What Country?: Allegany

11. Meritel Status: 1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementery/Secondary (0-12): 0; Collega (1-4or 5+): 0

16a. Decedant's Usual Occupation *(Giva kind of work done duning most of working lifa. DO NOT usa retired)*: none

16b. Kind of Business/Industry: none

17. Father's Name *(First, Middle, Last)*: Sean Lynn Whetzel

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Kristin michelle Steele

19a. Informant's Name/Ralationship *(Type, Print)*: Kristin Marie Whetzel

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: P.O. Box 225 Ridgeley WV 26753

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Ramovel from Steta 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Cumberland Crematory

Date: 1/10/2001

20c. Location - City or Town, Stata: Cumberland, MD

21. Signature of Funeral Sarvice Licensee: Robert C. Adams, Jr.

22. Nema end Addrass of Facility: Merritt-Adams Funeral Home, P.A. 404 Decatur St., Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona cause on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in death)

a. fetal anoxia

Due to (or as a consequence of):

b. Fetal lung immaturity

Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initiated avants resulting in death) Last

Due to (or as a consequanca of):

c. Immaturity

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signeture and title of certifier: Boyd Gaba MD

29c. Licensa number: D1837

29d. Data signed *(Month, Day, Year)*: 1-10-01

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print): Boyd Gaba, MD 921 Seton Dr., LaVale, MD 21502

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 10 2001

32. Registrar's Signatura: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02624

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen I. Wilson

2. Date of Death Month Day Year: Jan. 21 2001

3. Time of Death: 9:05pm

4a. Facility Name *(If not institution, give street and number)*: 96 Murray Road

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 232-30-8268

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 15, 1920

9. Birthplace *(State or Foreign Country)*: Forrest Co., N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 96 Murray Road

10f. Zip Code: 21921

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: housekeeper

16b. Kind of Business/Industry: Regency Nursing Home/housekeeping

17. Father's Name *(First, Middle, Last)*: Robe Hauser

18. Mother's Name *(First, Middle, Maiden Surname)*: Bertha Jane Flynn

19a. Informant's Name/Relationship *(Type, Print)*: Nancy Runyon (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 96 Murray Road Elkton, MD 21921

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gracelawn Memorial Park

Date: Jan. 25, 2001

20c. Location - City or Town, State: New Castle, DE

21. Signature of Funeral Service Licensee: ▶ Nicholas R. Ruble MD0788

22. Name and Address of Facility: McCrery Funeral Homes, Inc. 3924 Concord Pike Wilmington, DE 19803

Physician /Medical Examiner

rgw

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer — 6 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Barbara A Parey MD

29c. License number: D25915

29d. Date signed *(Month, Day, Year)*: 1-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barbara Parey, MD 111 W. High St. Elkton, MD 21921

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: B. Jones

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02625

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rachel Katherine Yedinak
2. Date of Death: Month January Day 12 Year 2001
3. Time of Death: 1710 P
4a. Facility Name (If not institution, give street and number): Laurelwood Care Center
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 218-01-2016
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): April 9, 1919
9. Birthplaca (State or Foreign Country): Maryland

Usual Rasidanca of Decedant

10a. Stata: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Street and Number: 1137 Singerly Road
10f. Zip Coda: 21921
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada compliatad): Elamentary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Homemaker
16b. Kind of Business/Industry: In Her Own Home

17. Fathar's Nama (First, Middla, Last): Roy DeMond
18. Mothar's Nama (First, Middla, Maidan Surname): Irene Kline

19a. Informant's Neme/Reletionship (Type, Print): Patricia K. Charshee/Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 144 Kennedy Boulevard, Elkton, Maryland 21921

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetery, crematory or othar placa): St. Rose of Lima Cemetery
Data: 1/17/01
20c. Location - City or Town, Stata: Chesapeake City, Maryland

21. Signatura of Funaral Sarvice Licensee: ▶ Donald S. Hicks
22. Nama and Addrass of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on each lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Cause (Final disaasa or condition rasulting in daath): a. Aortic Valve STenosis — 2 years

Dua to (or as a consaquance of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Dua to (or as a consaquance of):
c.
Dua to (or as a consaquanca of):
d.

Part II. Other significant conditions contributing to death but not rasulting in tha underlying causa given in Part I.: HyperTensive CardiomyopATHY; Coronary Artery Disease; CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Wara autopsy findings available prior to compliation of cause of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☑ No

26. Placa of Daath (Check only ona)
Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA
Other: 4☑ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Data of Injury (Month, Day Yaar)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurrad
28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only ona): 1☑ Cartifying Physician: To the best of my knowladga, daath occurrad at tha tima, data and placa, and due to the cause(s) and mannar as stated. 2☐ Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifier: ▶ Monte Makous, MD
29c. Licansa number: D-44783
29d. Data signed (Month, Day, Year): JANUARY 15, 2001

30. Nama and addrass of parson who completed cause of daath (Itam 23a) (Type, Print): MONTE MAKOUS, MD 111 West High STreet, ELKTON, MD 21921

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signatura: ▶ Sandra G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #19b, 1/18, 1/19/01, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02626

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HELEN VIRGINIA YONKER
2. Date of Death (Month, Day, Year): JAN 17 2001
3. Time of Death: 3:15 PM
4a. Facility Name (If not institution, give street and number): 10601 TOWN CREEK RD NE
4b. City, Town, or Location of Death: FLINTSTONE
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 219-76-6015
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 8, 1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: FLINTSTONE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10601 TOWN CREEK ROAD NE
10f. Zip Code: 21530
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLES VERNON CROCK
18. Mother's Name (First, Middle, Maiden Surname): EDNA LENA HARTMAN

19a. Informant's Name/Relationship (Type, Print): RICHARD H. YONKER-HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10601 ~~TOWN~~ TOWN CREEK RD NE, FLISTONE, MD 21530

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): HILLCREST MEMORIAL PARK | Date: JAN 20, 2001
20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Douglas S Hafer
22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY, 1302 NATIONAL HWY, LAVALE, MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. ACUTE Myocardial Infarction
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D0023371
29d. Date signed (Month, Day, Year): Jan 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. Q. ZAMAN, 625 KENT AVE., CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: Jeanne G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02627

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Brune Sr.

2. Date of Death Month: January Day: 31 Year: 2001

3. Time of Death: 1:45 Am

4a. Facility Name *(If not institution, give street and number)*: Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-42-4512

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 55 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 15 1945

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7483 Berkshire Road

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Business/Industry: Railroad

17. Father's Name *(First, Middle, Last)*: JOseph BRune

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Bowen

19a. Informant's Name/Relationship *(Type, Print)*: Judith Brune / wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8213½ Beach Drive Baltimore MD. 21222

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory Inc

Date: 2/01/02

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce Ave. Balitmore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Metastatic Lung Cancer — 10 mo

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cirrhosis of Liver

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D45390

29d. Date signed *(Month, Day, Year)*: JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MYO MIN, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Brune William

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02628

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAVIS L. BIDDLE
2. Date of Death (Month, Day, Year): Jan. 30, 2001
3. Time of Death: 5:05 AM
4a. Facility Name (If not institution, give street and number): Mariner Health of North Arundel
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-18-7922
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 26, 1920
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 905 Oakleigh Beach Road
10f. Zip Code: 21222
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Candy Assembler
16b. Kind of Business/Industry: C.M. Pitts

17. Father's Name (First, Middle, Last): James Earl Barnes
18. Mother's Name (First, Middle, Maiden Surname): Lilly May Muir

19a. Informant's Name/Relationship (Type, Print): George L. Barnes (brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 905 Oakleigh Beach Rd., Baltimore, Md. 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Glen Haven Memorial Pk. | Date: 02/03/01
20c. Location - City or Town, State: Glen Burnie, Maryland

21. Signature of Funeral Service Licensee: Kevin E Ecker
22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):
b. ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMER'S DEMENTIA.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: K. S. Dharmasena, M.D.
29c. License number: D17753
29d. Date signed (Month, Day, Year): 1/30/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. S. DHARMASENA, M.D. 710 CHURCH ST. BALTIMORE, MD 21225.

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02629

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILLIAN BRAGER

2. Date of Death: Month JANUARY Day 30 Year 2001

3. Time of Death: 1258 PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-05-4482

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 28, 1915

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4940 Pennington Avenue

10f. Zip Code: 21226

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lab Technician

16b. Kind of Business/Industry: American Oil Co.

17. Father's Name (First, Middle, Last): Walter Brager

18. Mother's Name (First, Middle, Maiden Surname): Sophie Jankowski

19a. Informant's Name/Relationship (Type, Print): Milton Brager (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 902 Wanda Rd., Linthicum, Maryland 21090

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery Date: 02/02/2001

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Kevin E Ecker

22. Name and Address of Facility: McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CEREBROVASCULAR ACCIDENT	1 DAY
Due to (or as a consequence of):	AND	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	MYOCARDIAL INFARCTION	1 DAY
Due to (or as a consequence of):	AND	
c.	ANEMIA	2 DAYS
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: INTENSIVE CARE UNIT RESIDENT

29c. License number: P13140

29d. Date signed (Month, Day, Year): JANUARY 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SAMEER BADE MD, 3001 S. HANOVER ST, BALTIMORE MD 21225

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02630

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marvin E. Botkin
2. Date of Death (Month, Day, Year): January 26, 2001
3. Time of Death: 4:30 pm
4a. Facility Name (If not institution, give street and number): Johns Hopkins - Bayview
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 233-44-4527
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 12, 1930
9. Birthplace (State or Foreign Country): WV.

Usual Residence of Decedent

10a. State: Md.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 6113 Cardiff Ave
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yas 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 yrs. | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Plumber
16b. Kind of Business/Industry: Plumbing

17. Fathar's Name (First, Middle, Last): Thomas Botkin
18. Mother's Name (First, Middle, Maiden Surname): Thel Neville

19a. Informant's Name/Relationship (Type, Print): Linda Steigwald Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1006 Gahle Rd. Westminister, Md. 21157

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Oaklawn Cemetery | Date: Jan 30 2001
20c. Location - City or Town, State: Dundalk, Md.

21. Signature of Funeral Service Licensee: ▶ Anthony C. Connelly
22. Name and Address of Facility: Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, MD. 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. COPD
Due to (or as a consequence of):
b. Hypertension
Due to (or as a consequence of):
c. Atrial Fibrillation
Due to (or as a consequance of):
d. Malnutrition

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residance 8 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: ▶ E Botsford
29c. Licensa number: D17202
29d. Date signed (Month, Day, Year): 2/2/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S.S. Dang MD 101 St. Helena Baltimore MD. 21222

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: ▶ Jeneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02631

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MATILDA W. BERLIN
2. Date of Death (Month, Day, Year): JANUARY 31, 2001
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): 6 POMONA NORTH #6
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-07-9283
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR.31,1910
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6 POMONA NORTH #6
10f. Zip Code: 21208
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): STATISTICAL ASSISTANT
16b. Kind of Business/Industry: SOCIAL SECURITY ADMIN.

17. Father's Name (First, Middle, Last): ABE WILK
18. Mother's Name (First, Middle, Maiden Surname): SARAH BOOK

19a. Interment's Name/Relationship (Type, Print): HARRIETT BOSCH / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 POMONA NORTH #6 - BALTIMORE, MD 21208

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MIKRO KODESH BETH ISRAEL
Date: 2/2/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Scott M. Cuttler
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive heart failure	2 years
Due to (or as a consequence of): b.	Coronary artery disease	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	aortic valve disease	5 years
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dr Harry W. Kaplan, MD
29c. License number: D40371
29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Harry Kaplan MD 90 Paintersmill Rd Owings Mills, MD 21117

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Brenda D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

01-533-005
LEO BRUNE
JVW

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02632

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leo James Brune	FEBRUARY 01, 2001	12:10 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
917 BREEZEWICK CIRCLE	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
215-30-7058	1 [X] M 2 [ ] F	68 Yrs.					September 24, 1932	Baltimore, Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore Co.	Towson	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
917 Breezewick Circle	21286-3302	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Korean Conflict	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	N/A	Field Service Supervisor	Ward Machinery

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Francis J. Brune	Mary Ellen Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorothea Rebecca(nee Kakel)Brune(Wife)	917 Breezewick Circle Towson, Maryland 21286-3302

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Druid Ridge Cemetery	02/03/2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee: Jeffrey L. Gair, Sr. — Jeffrey L. Gair, Sr.

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. HEAD INJURIES IN ASSOCIATION WITH HYPERTENSIVE	
	~~Due to (or as a consequence of):~~	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1/31/01 FOUND	P M	1 [ ] Yes 2 [X] No	SUBJECT FELL DOWN STAIRS

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): AT HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 917 BREEZEWICK CIRCLE, TOWSON, MD

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
M.D.	O.C.M.E.	FEBRUARY 01, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	Jenna G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12+1

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02633

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nellie Jane Barrett
2. Date of Death (Month, Day, Year): January 30 2001
3. Time of Death: 8:47 PM
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 227-24-9343
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 15, 1915
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 158 Riverside Road
10f. Zip Code: 21221
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Hughes
18. Mother's Name (First, Middle, Maiden Surname): Rosa Lillie Mayberry

19a. Informant's Name/Retelionship (Type, Print): Brenda Staniford (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 158 Riverside Road Essex, Maryland 21221

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment
20b. Place of Disposition (Name of cemetery, crematory or other place): Holly Hill Mem. Gdns.
Date: 2/2/2001
20c. Location - City or Town, State: Middle River, MD

21. Signature of Funeral/Service Licensee: ▶ Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech tine.

		Approximate Interval Between Onset and Death
Immediete Cause (Final disease or condition resulting in death) a.	Myocardial Infarction	2 hours
Due to (or as s consequence of): b.	Congestive Heart Failure	1 day
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last — Due to (or es e consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D53462
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUDE MUNESES, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: ▶ Geneva D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Barrett Nellie

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02634

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALFRED BUISE

2. Date of Death: Month January Day 30 Year 2001

3. Time of Death: 6:06PM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-72-3038

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 44 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): 04-05-56

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 736 Richwood Avenue

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Maritel Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 11th Grade

College (1-4or 5+): NA

16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired): Stock Clerk

16b. Kind of Business/Industry: Whole Food Markets

17. Father's Neme (First, Middle, Last): Alfred Buise, Sr.

18. Mother's Neme (First, Middle, Maiden Surneme): Lagertha Jeffries

19a. Informent's Neme/Reletionship (Type, Print): Rhonda Buise

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3929 Boarman Avenue Baltimore, Maryland 21215

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): King Mem. Pk. Cem. Date: 02-05-01

20c. Location - City or Town, State: Randallstown, MD

21. Signeture of Funeret Service Licensee: ▶ Gladys Wana

22. Neme end Address of Fecility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Part1. Enter the disease, or compticetions thet caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediete Cause (Finet diseese or condition resulting in deeth) a.	Intraabdominal sepsis	Two days
Due to (or es a consequence of):		
Sequentiellty tist conditions, if sny, teeding to immediete cause. Enter Underlying Cause (Disease or injury thet tritieted events resulting in death) Lest b.	closed loop bowel obstruction	Two days
Due to (or es e consequence of):		
c.	appendicitis	nine days
Due to (or es a consequence of):		
d.		

Pert tI. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: diabetes mellitis

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Neturat 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigetion 6 ☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of tnjury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of tnjury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete snd piece, end due to the ceuse(s) and menner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner steted.

29b. Signeture and title of certifier: Theresa Lynn Hartsell MD, PhD

29c. License number: RES-000

29d. Date signed (Month, Dey, Year): JANUARY 30, 2001

30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print): THERESA LYNN HARTSELL 600 NORTH WOLFE STREET BALTIMORE, MD 21287-9106

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signeture: ▶ B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02635

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Doris J. Beacher

2. Date of Death: Month Jan, Day 31, Year 2001

3. Time of Death: 5:15 PM

4a. Facility Name (If not Institution, give street and number): 1257 James Street

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215-20-6257

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 2, 1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1257 James Street

10f. Zip Code: 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line Box Packer

16b. Kind of Business/Industry: Maryland Paper Box

17. Father's Name (First, Middle, Last): William Mortzfeldt

18. Mother's Name (First, Middle, Maiden Surname): Helen Perry

19a. Informant's Name/Relationship (Type, Print): Alfred R. Beacher / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1257 James Street, Baltimore, Maryland 21223

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cedar Hill Cemetery

Date: 2/3/01

20c. Location - City or Town, State: Brooklyn Park, Maryland

21. Signature of Funeral Service Licensee: Juanita R Thomas

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Raymond Miller MD

29c. License number: D47643

29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Miller 25 Main Street Suite 200 Reisterstown MD

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Geneva G. Woods

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02636

AMENDED ITEMS #10e,18 per fh G792 020201 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
LOUIS	BERGERSON	JANUARY 29, 2001	10:50PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
HEBREW HOME OF GREATER WASHINGTON	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-05-9405	XX 1☐M 2☐F	83 Yrs.			JAN.17,1918	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	POTOMAC	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11812 ~~BECKMAN~~ Beekman PLACE	20854	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		SALESMAN	FURNITURE

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
SAMUEL BERGERSON	LENA Diamon ~~DIAMOND~~

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ERIC BERGERSON / SON	11812 BEEKMAN PLACE - POTOMAC, MD 20854

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	MD VETERANS CEMETERY	2/1/01	OWINGS MILLS, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael Bruger	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	1 day
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Parkinsons Disease

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☑No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☑No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☑Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Gregory A Compton MD	D24942	JAN 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	Jennifer G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0505-510

ELLEN

CROUT AMENDED ITEMS# 23a,b & 27 per M.E. G792 020701 SS

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02637

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Ellen Theresa Crout	JANUARY 30, 2001	3:07P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHOCK TRAUMA CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-26-8027	1☐ M 2☒ F	69 Yrs.			June 9, 1931	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	N/A	Baltimore City	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1435 Haubert Street	21230	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	0	Bank Clerk	Banking

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
John Ridgway	Mary Brown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Kathaleen A. Crout / Daughter	1435 Haubert Street, Baltimore MAryland 21230

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Bayview Crematory	February 2, 2001	Baltimore Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Victor P. Doda, Jr.	Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS AND MULTI ORGAN FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CELLULITIS AND NECROTIZING FASCIITA OF RIGHT LOWER EXTREMITY

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chuteno	O.C.M.E.	JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chuteno 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02638

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joyce A. Chatterton

2. Date of Death: Month JANUARY Day 29 Year 2001

3. Time of Death: 2:20 PM

4a. Facility Name (If not institution, give street and number): HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-74-5615

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 17, 1956

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore City

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 756 E. Fort Avenue, 2nd Floor

10f. Zip Code: 21230

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John Hubert Chatterton

18. Mother's Name (First, Middle, Maiden Surname): Joan A. Brown

19a. Informant's Name/Relationship (Type, Print): David Lafferty / Step Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 756 E. Fort Avenue, 2nd Floor Baltimore Maryland 21230

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bayview Crematory

Date: February 2, 2001

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	ESOPHAGEAL CARCINOMA	14 MONTHS
Due to (or as a consequence of): b.	TRACHEOESOPHAGEAL FISTULA	14 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Shakil MD

29c. License number: RES 000

29d. Date signed (Month, Day, Year): JANUARY 30th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMNA SHAKIL, 3001 S HANOVER STREET, BALTIMORE, MD 21225

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02639

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ellen Chambers

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 4:50pm

4a. Facility Name *(If not institution, give street and number)*: Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-64-0416

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 06-02-44

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 215 S. Ellwood Avenue

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+): NA

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: in home

17. Father's Name *(First, Middle, Last)*: Wilson Robinson

18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Porter

19a. Informant's Name/Relationship *(Type, Print)*: Tarnisha Williams

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 215 S. Ellwood Avenue Baltimore, MD 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King Mem. Pk. Cemetery

Date: 02-03-01

20c. Location - City or Town, State: Randallstown MD

21. Signature of Funeral Service Licensee: Gladys Warner

22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acquired immunodeficiency syndrome

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: 89377

29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Govind Mukundan, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

CHAMBER ELLEN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02640

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT COSTELLO
2. Date of Death (Month, Day, Year): JANUARY 25 2001
3. Time of Death: 10 10 AM
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS BAYVIEW GERIATRIC CENTER
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 187-22-9726
6. Sex: 1 XX M 2 ☐ F
7. Age (In yrs. last birthday): 69 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 17, 1931
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Odenton
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1205 Winer Road
10f. Zip Code: 21113
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1952-70
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Deputy Director of Logistics
16b. Kind of Business/Industry: Dept. of Defense

17. Father's Name (First, Middle, Last): John Costello
18. Mother's Name (First, Middle, Maiden Surname): Marion Hare

19a. Informent's Name/Relationship (Type, Print): Robert D. Costello, Jr. (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7941 Stone Hearth Road, Severn, MD 21144

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.
Date: 02/01 2001
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Patrick J. Arnold
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	CARDIAC ARRHYTHMIA	MINUTES
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	ISCHEMIC CARDIOMYOPATHY	YEARS
Due to (or as a consequence of):		
c.	ANEMIA	YEARS
Due to (or as a consequence of):		
d.	GASTROINTESTINAL BLEED	DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RECURRENT NON-SMALL CELL LUNG CANCER
PULMONARY HYPERTENSION, AORTIC STENOSIS
AORTIC INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: WRED D
29c. License number: D047383
29d. Date signed (Month, Day, Year): JANUARY 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERIC HOCHBERG, PAC 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE MD 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02641

CEAFOSS, DAVID A.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David A. Cearfoss
2. Date of Death (Month, Day, Year): JANUARY 30, 2001
3. Time of Death: 3:30PM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: AA COUNTY

Funeral Director

5. Social Security Number: 217-46-3878
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11 6 1947
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Catonsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2116 Arlonne Drive
10f. Zip Code: 21228
10g. Citizen of What Country?: USA
11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5±
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Contractor
16b. Kind of Business/Industry: Own Business
17. Father's Name (First, Middle, Last): Arthur R. Cearfoss
18. Mother's Neme (First, Middle, Meiden Surname): Phyllis Ziehm
19a. Informant's Name/Relationship (Type, Print): Victoria Cearfoss Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2116 Arlonne Drive Baltimore, MD 21228
20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other piece): Stevensville Cemetery
Date: 02/03/01
20c. Location - City or Town, Stete: Stevensville, MD
21. Signature of Funeral Service Licensee: Peter S. Ashton Nagoli
22. Name and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac ventricular fibrillation — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
b. Hypertensive Arteriosclerotic coronary desease — years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)
Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Neturat 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigetion, In my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Laurence R. Gallagher, MD
29c. License number: D 01786
29d. Date signed (Month, Dey, Year): JAN. 31, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): LAURENCE R. GALLAGER, M.D. 716 MAIDENCHOICE LANE, BALTO, MD. 21228

State Registrar

31. Date filed (Month, Dey, Year): FEB 02 2001
32. Registrar's Signeture: Lawrence G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02642

amend item 24a per verbal response G792 2/2/01 yf

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): Harry Cook

2. Date of Death: Month 1 Day 28 Year 01

3. Time of Death: 4:50 am

4a. Facility Name (If not institution, give street and number): Future Care, 5412 Old Court Rd.

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

5. Social Security Number: 212-07-1970

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 28, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3301 Fairview Road

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Aircraft Mechanic

16b. Kind of Business/Industry: Martin Marrietta

17. Father's Name (First, Middle, Last): Harry Augustus Cook, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Katherine Elizabeth Lentz

19a. Informant's Name/Relationship (Type, Print): Dale Cook (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3301 Fairview Road; Baltimore, Maryland 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lake View Cemetery

Date: 1/31/01

20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: Joseph D. Kellner M00733

22. Name and Address of Facility: Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiorespiratory Arrest

Due to (or as a consequence of):

b. advanced Stage C.O.PD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. D.V.T. (Deep Vein Thrombosis) Rt. Leg.

Due to (or as a consequence of):

d. Congestive Heart Failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D46267

29d. Date signed (Month, Day, Year): 1/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julius Boateng 5310 Old Court Rd Suite 201 Randallstown MD 21133

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02643

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILTON J. DLUBALA

2. Date of Death: Month February Day 1 Year 2001

3. Time of Death: 11:55 PM

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-09-7236

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 27 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Pasadena

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2 Cedar Circle

10f. Zip Code: 21122

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Longshoreman

16b. Kind of Business/Industry: Steamship Trade Co.

17. Father's Name (First, Middle, Last): John Dlubala

18. Mother's Name (First, Middle, Maiden Surname): Victoria Mackowiak

19a. Intormant's Name/Relationship (Type, Print): Mary C. Dlubala (Sister-in-Law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 Cedar Circle, Pasadena, Md. 21122

20a. Method ot Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place ot Disposition (Name of cemetery, cremetory or other place): Cedar Hill Cemetery Date: 2/05/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: Richard Pickett

22. Name end Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line.

Approximate Intervei Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Due to (or as a consequence ot): — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence ot):

c. Due to (or as e consequence of):

d.

Part tt. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic obstructive pulmonary disease

23b. Did tobacco uaa contributs to the cause of death? 1 [ ] Yas 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy tindings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Place ot Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece ot Injury - At home, farm, street, tactory, office building, etc. (Specify)

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end piece, and due to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: Hwan Y. Yoo M.D.

29c. License number: D0053514

29d. Date signed (Month, Day, Year): February 1 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hwan Y. Yoo, MD. North Arundel Hospital.

State Registrar

31. Date tiled (Month Day Year): FEB 02 2001

32. Registrar's Signature: Bernice G. Hooks

ORIGINAL

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Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Milton J. Dlubala

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02644

NAME KNOWN TO PHYSICIAN: DANIELS, MORRIS C

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MORRIS CLAYTON DANIELS

2. Date of Death (Month, Day, Year): JANUARY 30, 2001

3. Time of Death: 6:00PM

4a. Facility Name (If not institution, give street and number): VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death: PERRY POINT

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 240-36-8543

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 28 1926

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1807 Jackson Street

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 9

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Self-employed

17. Father's Name (First, Middle, Last): Joe Daniels

18. Mother's Name (First, Middle, Maiden Surname): Viola Peele

19a. Informant's Name/Relationship (Type, Print): Christine Schaffer (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1307 Shady Glen Drive, District Heights Md. 20747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wayne Memorial Park

Date: 2/05/2001

20c. Location - City or Town, State: Dudley, N.C.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 20 MINUTES

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC HEART DISEASE — UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER"S DEMENTIA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 151094-1

29d. Date signed (Month, Day, Year): JANUARY 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MELECIA SANTOS, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02645

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SAMUEL DAVIS JR.

2. Date of Death Month / Day / Year: JANUARY 31, 2001

3. Time of Death: 2:20am

4a. Facility Name *(If not institution, give street and number)*: 3704 ECHODALE AVE.

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N / A

Funeral Director

5. Social Security Number: 218-44-3957

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 26, 1947

9. Birthplace *(State or Foreign Country)*: BALTO. MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3704 ECHODALE AVE.

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* AFRO AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4th — College (1-4 or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ROOFER

16b. Kind of Business/Industry: FRICK BROS

17. Father's Name *(First, Middle, Last)*: SAMUEL S. DAVIS SR.

18. Mother's Name *(First, Middle, Maiden Surname)*: BERTHA MORTON

19a. Informant's Name/Relationship *(Type, Print)*: BERTILLA DAVIS (SISTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3704 ECHODALE AVE. BALTO. MD. 21206

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOUNT ZION CEMETERY

Date: FEBRUARY 3, 2001

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Calvin B. Scruggs

22. Name and Address of Facility: CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON STREET BALTO. MD. 21213

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Leukemia — Five months

Due to (or as a consequence of):
b. Fungal pneumonia — Two months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mary Jo Lechowicz MD

29c. License number: D0056692

29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MaryJo Lechowicz MD 401 North Broadway Baltimore, Maryland 21231

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02646

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene Paul Driscoll

2. Date of Death: Month: January Dey: 30 Year: 2001

3. Time of Death: 1755

4a. Facility Name (If not institution, give street and number): St. Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-26-7489

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 11, 1930

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Baltimore Highlands

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3012 Michigan Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1952-1954

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Newspaper Production

17. Father's Name (First, Middle, Last): Joseph P. Driscoll

18. Mother's Name (First, Middle, Meiden Surneme): Minnie Maxeiner

19a. Intormant's Name/Relationship (Type, Print): Juanita Driscoll, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3012 Michigan Ave. Baltimore Highlands, MD.21227

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Parkwood Cemetery

Date: 2-3-01

20c. Location - City or Town, State: Parkville, MD

21. Signature of Funeral Service Licensee: Rebecca Robison

22. Name end Address of Facility: Ambrose Funeral Home of Lansdowne
2719 Hammonds Ferry Rd. Arbutus, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death): a. Prostate Cancer — 9 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Pert tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Mehdi Azadi, PGY II

29c. License number: P13598

29d. Date signed (Month, Day, Year): January 31 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Mehdi Azadi, MD 900 Caton Ave Baltimore, MD 21229

State Registrar

31. Dete filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Jeanne G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Eugene Driscoll

10

11/1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02647

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALBERT FRANCE

2. Date of Death Month / Day / Year: JANUARY 28, 2001

3. Time of Death: 6:40 AM

4a. Facility Name *(If not institution, give street and number)*: FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 213-03-2028

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 1-5-1917

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: HOWARD

10c. City, Town or Location: COOKESVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2240 RT. 97

10f. Zip Code: 21723

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): -12- / College (1-4or 5+): -0-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINE OPERATOR

16b. Kind of Business/Industry: FACTORY

17. Father's Name *(First, Middle, Last)*: LOUISE FRANCE

18. Mother's Name *(First, Middle, Maiden Surname)*: SARAH BERRY

19a. Informent's Name/Relationship *(Type, Print)*: ROMONA HALL(NIECE)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2324 MILLERSVILLE RD. COOKESVILLE, MARYLAND 21723

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FRANCE FAMILY LOT

Date: 2-2-2001

20c. Location - City or Town, State: COOKESVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Vernon L. Bailey

22. Name and Address of Facility: VERNON BAILEY FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)

a. Recurrent Aspiration Pneumonia — 12hours

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Gastroesophageal reflux

Due to (or as e consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CVA, Hypertension, Prostate Ca

(L)leg D.V.T

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Was case referred to medicat examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only* one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piaca of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or Investigetion, in my opinion, death occurred at the time, dete and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: James S. Grisson MD

29c. License number: D21944

29d. Date signed *(Month, Day, Year)*: 1/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James S. Grisson MD 300 W. 9th St. Frederick, Md. 21701

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Brenda B Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02648

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES DELANEY FAULKNER JR.
2. Data of Death — Month: January Day: 28, Year: 2001
3. Time of Death: 1:17 pm
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-64-6871
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 18, 1954
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 2412 EDMONDSON AVENUE
10f. Zip Code: 21229
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: WORKSHOP FOR THE BLIND

17. Father's Name (First, Middle, Last): JAMES DELANEY FAULKNER SR.
18. Mother's Name (First, Middle, Maiden Surname): MARY CONYERS

19a. Informant's Name/Relationship (Type, Print): JAMES D. FAULKNER SR. (FATHER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2021 W. BALTIMORE STREET, BALTIMORE, MD. 21223

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 02-02-01
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Terminal Acquired Immune Deficiency Syndrome
Due to (or as a consequence of):
b. Coagulopathy
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Mien-Door Kioune, MD
29c. License number: D31865
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mien-Door Kioune, M.D. c/o Maryland General Hospital

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

James Faulkner

B-2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02649

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARION C. FALLS, JR.

2. Date of Death (Month, Day, Year): FEBRUARY 1, 2001

3. Time of Death: 3:00 A.M.

4a. Facility Name (If not institution, give street and number): GENESIS ELDERCARE - SEVERNA PARK

4b. City, Town, or Location of Death: SEVERNA PARK

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 246-01-8007

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR. 24, 1923

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 411 6TH AVE., N.E.

10f. Zip Code: 21060

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPPLIES SPECIALIST

16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): MARION C. FALLS, SR.

18. Mother's Name (First, Middle, Maiden Surname): RUTH LONG

19a. Informant's Name/Relationship (Type, Print): GARY E. FALLS / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 503 SARATOGA AVE., GLEN BURNIE, MARYLAND 21060

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): CROWNSVILLE MD VET. CEM.

Date: FEB. 5 2001

20c. Location - City or Town, State: CROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Dementia — 2 months

Due to (or as a consequence of):

b. Cerebro vascular Accident — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D53462

29d. Date signed (Month, Day, Year): FEB. 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JUDE MUNESES, M.D., 7845 OAKWOOD RD., GLEN BURNIE, MARYLAND 21061

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02650

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen E. Fisher
2. Date of Death Month Day Year: Jan 30 2001
3. Time of Death: 11:06AM
4a. Facility Name (If not institution, give street and number): 2610 Calvary Rd.
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 188-16-3601
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 15 1922
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Md
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 700 W. Bel Air Ave. #420
10f. Zip Code: 21001
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): —
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: home

17. Father's Name (First, Middle, Last): John H. Rupp
18. Mother's Neme (First, Middle, Meiden Surneme): Helen V. Swingler

19a. Informant's Name/Reletionship (Type, Print): Mark S. Fisher SON
19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 11615 Redfield Rd. Bel Air, Md 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Harford Mem. Gdns | Date: Feb 3 2001
20c. Location - City or Town, State: Aberdeen Maryland

21. Signature of Funeral Service Licensee: Kenta L Wells
22. Name and Address of Facility: Evans Funeral Chapel 3 Newport Dr. Forest Hill, Md 21050

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth) e.	Hodgkin's Lymphoma.	4 Months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury thet initiated events rasulting in death) Last b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal feulure. Atrial fibrillation. Congestive Heart-feulure

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Grand Son's Home.

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William, MD
29c. Licensa number: D 32609
29d. Date signed (Month, Dey, Year): 2/1/01.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kamnachan Miliani MD 1106 Revolution St. Havre De Grace MD 21078

State Registrar

31. Date filed (Month, Dey, Year): FEB 02 2001
32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02651

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Etta Fields
2. Date of Death Month: 1 Day: 31 Year: 01
3. Time of Death: 10:00Am
4a. Facility Name *(If not institution, give street and number)*: Manor Care Health Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: NA

Funeral Director

5. Social Security Number: 214-16-6307
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 103 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 01-22-1898
9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decadent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2514 Barclay Street
10f. Zip Code: 21218
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4th Grade; College (1-4or 5+): NA
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic
16b. Kind of Business/Industry: in & out of home

17. Father's Name *(First, Middle, Last)*: Tom Ware
18. Mother's Name *(First, Middle, Maiden Surname)*: Ginny Ware

19a. Informant's Name/Relationship *(Type, Print)*: Linda Fields
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 345 East 29th Street Baltimore, Maryland 21218

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Woodlawn Cemetery
Date: 02-03-01
20c. Location - City or Town, State: Woodlawn, MD

21. Signature of Funeral Servica Licansee: Gladys Warner
22. Name and Address of Facility: Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SUBDURAL HEMATOMA & SUBARACHNOID HEMORRHAGE — 45 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
b. HYPERTENSION

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D16619
29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): C. VERGARA-SOARES 4669 FALLS ROAD BALTIMORE, MD. 21209

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrer's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02652

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shirley Foy
2. Date of Death — Month: JAN. Day: 31 Year: 2001
3. Time of Death: 0135 a.m.
4a. Facility Name *(If not institution, give street and number)*: ST. AGNES HEALTHCARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: NA

Funeral Director

5. Social Security Number: 246-78-2525
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 52 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 09-26-48
9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5305 Overhill Road
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): High Sch. Grad — College (1-4or 5+): NA
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor
16b. Kind of Business/Industry: Image Graphics
17. Father's Name *(First, Middle, Last)*: Sam Kearney
18. Mother's Name *(First, Middle, Maiden Surname)*: Pattie Hardy
19a. Informant's Name/Relationship *(Type, Print)*: Donald Foy
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5305 Overhill Road Baltimore, Maryland 21207
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD. Nat'l Mem. Pk. Cem. — Date: 02-05-01
20c. Location - City or Town, State: Laurel, MD
21. Signature of Funeral Service Licensee: ▶ Gladys Warner
22. Name and Address of Facility: WM.C.March FH 1101 E. North Avenue Baltimore, Maryland 21202

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. OVERWHELMING SEPSIS

Due to (or as a consequence of):
b. NECROTIZING FASCIITIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. DIABETES - NEWLY DIAGNOSED.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: ▶ Ganti SURGERY RESIDENT. PGY II
29c. License number: AS243552 21187
29d. Date signed *(Month, Day, Year)*: JAN. 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.L. GANTI ST. AGNES HEALTHCARE, 900 CATON AVENUE, BALTIMORE, MD

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signeture: ▶

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME SHIRLEY FOY

48-6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02653

Physician / Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joan Prudence Fossett
2. Date of Death Month: January Day: 31 Year: 01
3. Time of Death: 1230
4a. Facility Name *(If not institution, giva street and number)*: Deaton Specialty Home & Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 116-28-6699
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 2, 1936
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. Steta: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2103 Meadowview Drive
10f. Zip Code: 21207
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar In U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Giva Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indien, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fether's Neme *(First, Middle, Last)*: Chester Yardman
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Haynes

19a. Informent's Name/Relationship *(Type, Print)*: Birchard C. Fossett (Husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2103 Meadowview Drive, Baltimore, MD 21207

20a. Melhod of Disposition: ☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Maryland Veterans Cem.
Dete: 02/05 2001
20c. Location - City or Town, Stete: Crownsville, MD

21. Signature of Funeral Service Licensee: ▶ Patrick J. Hardesty
22. Nama and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician / Medical Examiner

23a. Part1. Entar the diseese, or complications that causad tha daath. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceusa on eech line.

		Approximele Intarvel Between Onset and Death
Immediate Cause (Final diseese or condition resulting in daath) e.	Myocardial infarction	1 day.
Due to (or es e consequenca of):		
Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Ceuse (Diseese or Injury thet initieted events resulting in daath) Last — b.	cerebrovascular accident	1 yr.
Due to (or es e consequenca of):		
c.	Diabetes mellitus	yrs
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to deeth but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Wara eutopsy findings svaileble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only ona)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☑ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledga, deeth occurred et the time, dete end placa, end due to the ceusa(s) and mannar es steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: ▶ C Mehta MD
29c. Licensa number: D 34974
29d. Date signed *(Month, Dey, Year)*: Jan. 31, 2001

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print): CHARU MEHTA, MD. 8775 cloud leaf ct #224, Columbia, MD 21045

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrer's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Fossett Joan

5

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02654

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARLES F GUTHRIE
2. Dete of Deeth: Month JAN Day 31 Year 2001
3. Time of Death: 4:00pm
4e Facility Name *(If not institution, give street end number)*: 1500 Barkley Ave.
4b. City, Town, or Location of Death: Essex
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-24-8010
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 71 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: March24 1929
9. Birthplace *(State or Foreign Country)*: MAryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1500 Barkley Ave.
10f. Zip Code: 21221
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8th | College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Driver
16b. Kind of Business/Industry: Truck

17. Father's Name *(First, Middle, Last)*: John Guthrie
18. Mother's Name *(First, Middle, Maiden Surname)*: CAtherine Cooper

19a. Informent's Neme/Relationship *(Type, Print)*: Eureth E Guthrie/wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1500 Barkley Ave. Baltimore Md. 21221

20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Holly Hill Cemetery
Dete: 2/3/01
20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name end Address of Facility: Connelly Funeral Home of Essex 300 MAce AVe. Baltimore MD 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth)
a. METASTATIC PROSTATE CANCER. — 4 years
Due to (or es a consequenca of):
b.
Due to (or as a consequenca of):
c.
Due to (or es e consequenca of):
d.

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to *medical* examiner? 1☐Yes 2☐No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and placa, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ [signature] M.D.
29c. License number: P14663.
29d. Dete signed *(Month, Day, Year)*: 02/01/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIKE CUSPIR M.D. VA Hospital Greene St. Balto. MD

State Registrar

31. Dete filed *(Month, Day, Year)*: 2/1/01
32. Registrar's Signature: ▶ FEB 02 2001 Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02655

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Gloria Mae Gempp
2. Dete of Deeth — Month: Jan 30 Dey Year: 2001
3. Time of Death: 1:28pm
4a. Facility Name *(If not institution, give street end number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 168-24-3162
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthdey)*: 70 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Sept 30 1930
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usuel Residence of Decedent

10a. Stete: Md
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1708 K Landmark Dr.
10f. Zip Code: 21050
10g. Citizan of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Spacify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+): +3
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Registered Nurse
16b. Kind of Business/Industry: Harford County Dept of Health

17. Father's Neme *(First, Middle, Last)*: Charles F. Baerhaet
18. Mother's Neme *(First, Middle, Maiden Surname)*: Alice L. Powell

19a. Informant's Neme/Relationship *(Type, Print)*: Robert A. Gempp
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1708 K Landmark Dr. Forest Hill, Md 21050

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Placa of Disposition *(Nama of cemetery, cremetory or other piece)*: Moreland Mem. Park — Deta: Feb 3 2001
20c. Location - City or Town, Stete: Parkville, Md
21. Signature of Funeral Service Licensee: Linda L Wells
22. Name end Address of Facility: Evans Funeral Chapel 8800 Harford Rd. Baltimore, Md 21234

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line. — Approximate Intervel Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in daeth)
a. PANCREATIC CANCER
Due to (or as a consaquance of):
b.
Due to (or as a consequance of):
c.
Due to (or es e consequence of):
d.

Sequentielly list conditions, if any, leading to immediete causa. Enter Underlying Cause (Disaase or Injury thet initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contributs to the causes of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case refarred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Rasidance 6☒ Other *(Specify)* HOSPICE
27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be datarmined
28a. Placa of Injury - At homa, farm, streat, factory, office building, etc. *(Specify)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Dete of Injury *(Month, Dey Yeer)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at tha tima, data and place, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at tha tima, data and place, end due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier:
29c. License number: D43725
29d. Date signed *(Month, Dey, Yeer)*: 2/2/01
30. Name and address of parson who completed causa of deeth (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrer's Signeture: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

JANUARY 30, 2001 1:28 p.m.

Division of Vital Records, P.O. Box 68760,

GLORIA GEMPP

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 25, 26 PER PHY G791 2-2-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02656

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leona June Gentile	January 29, 2001	4:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Bayview Medical Ctr.	Baltimore City	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
198-22-1369	1☐ M 2☒ F	72 Yrs.			Oct. 6,1928	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Dundalk	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6917 German Hill Road	21222	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12 Years		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Peter Albert Champainy	Frances Sophie Zuber

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Monica L. Cimaglia (Daughter)	8174 Midhaven Road Dundalk, Maryland 21222

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Oak Lawn Cemetery	Feb. 2,2001	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrhythmia	1 hr.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	D45475	1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mohammad Rahnama M.D. 8100 Harford Road Baltimore, Maryland 21234

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02657

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marjorie Patricia Grempler

2. Date of Death: Month 01 | Day 28 | Year 2001

3. Time of Death: 0620

4a. Facility Name (If not institution, give street and number): Saint Agnes Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 218-32-0420

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months | Days

If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): Jan 23, 1936

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1546 Clairidge Road

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management Assistant

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Milton T. Rowan

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Margeurite Beckett

19a. Informant's Name/Relationship (Type, Print): Patricia Grempler / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5940 St. Marys Street, Baltimore, Maryland 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Memorial Park

Date: 2/2/01

20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: ▶ Ann G. Zink

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung disease — Due to (or as a consequence of): — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Myocardial infarction

S/P coronary artery bypass grafts

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Melissa Burke MD

29c. License number: D36765

29d. Date signed (Month, Day, Year): 01/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Melissa Burke MD Dept Path. St Agnes Hosp 900 Caton Ave Balt. MD 21229.

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Grempler, Marjorie P

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02658

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Susan Marie Hudgins
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 5:00 AM
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-50-5688
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 5, 1946
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6601 Glenoak Ave
10f. Zip Code: 21214
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Program Director
16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: James Lawrence Hudgins
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Gertrude Reed

19a. Informant's Name/Relationship *(Type, Print)*: Sonya Maria Konstans/ daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6601 Glenoak Ave., Baltimore, MD 21214

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory, Inc
Date: 2/1/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stella D. Lohrmann
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. OVARIAN CANCER
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D 43725
29d. Date signed *(Month, Day, Year)*: 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

JANUARY 31, 2001 5:00 a.m.

SUSAN HUDGINS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02659

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BARBARA MAE HARRIS
2. Date of Death Month / Day / Year: JAN. 30 2001
3. Time of Death: 11:11 PM
4a. Facility Name *(If not institution, give street and number)*: JOSEPH RICHEY HOSPICE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 291-20-7433
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MARCH 25, 1925
9. Birthplace *(State or Foreign Country)*: NEW JERSEY

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4611 MAINE AVENUE
10f. Zip Code: 21207
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 3 YRS
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NURSE
16b. Kind of Business/Industry: MT. SINAI HOSPITAL

17. Father's Name *(First, Middle, Last)*: BENJAMIN FRANKLIN SWIFT SR.
18. Mother's Name *(First, Middle, Maiden Surname)*: LOUISE SUSAN DENNISON

19a. Interment's Name/Relationship *(Type, Print)*: LAWRENCE HARRIS (SON)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 16705 WARDLOW RD. UPPER MARLBORO, MD 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: DRUID RIDGE CEMETERY | Date: 02-03-01
20c. Location - City or Town, State: PIKESVILLE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic Colon Carcinoma — 2yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Tredell W. Iglehart III MD
29c. License number: D33400
29d. Date signed *(Month, Day, Year)*: January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: Tredell W. Iglehart III MD 500 W University Pkwy Baltimore MD 21210

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BARBARA HARRIS 1-30-01 11:11 PM

01-0462-510
CJ
Torrell Mitchell Hooks

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02660

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TORRELL MITCHELL HOOKS
2. Date of Death: Month January, Day 27, Year 2001
3. Time of Death: 09:05 P.M.
4a. Facility Name (If not institution, give street and number): 4200 block Loch Raven Boulevard
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-17-5492
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 23 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 25, 1978
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1630 KINGSWAY ROAD
10f. Zip Code: 21218
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12TH GRADE; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: CAR WASH

17. Father's Neme (First, Middle, Last): DELROY M. HOOKS JR.
18. Mother's Neme (First, Middle, Maiden Surneme): SHEILA TROY

19a. Informent's Name/Relationship (Type, Print): SHEILA HOOKS (MOTHER)
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 1630 KINGSWAY ROAD, BALTIMORE, MD. 21218

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY Date: 02-03-01
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217

Physician /Medical Examiner

29a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death): a. Multiple Gunshot Wounds
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Last: b. Due to (or es a consequence of): c. Due to (or es e consequence of): d.

Part ff. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medicel examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Scene
27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year): 1-27-01
28b. Time of Injury: 21:02 PM
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subj cct shot
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): street
28f. Location (Street end Number or Rural Route Number, City or Town, Stete): 4200 Blk Loch Raven Baltimore, Md

29a. Certifier (Check only one): 1 [ ] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and plece, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifier: Dennis J. Chuteau
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 28, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): FEB 02 2001
32. Registrer's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0471-510
B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

TROY HORTON SR. AMEND ITEM #20b PER TH G797 7/02/01 JH
AMENDED ITEMS# 23a,27,28a-f per M.E. G792 020801 SS

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2001 02661

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Troy Horton Sr.
2. Date of Death Month Dey Year: JAN. 28, 2001
3. Time of Death: 1417 PM
4e. Facility Name (If not institution, give street and number): 1513 MOSHER STREET
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-80-6941
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 41 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan.26,1960
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1635 N. Warwick Ave.
10f. Zip Code: 21216
10g. Citizen of What Country: USA

11. Maritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: African American

15. Decedent's Education (Specify only highest grede completed)
Elementery/Secondery (0-12): 10
College (1-4or 5+): 8
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Cook
16b. Kind of Business/Industry: Local Restaurants

17. Father's Neme (First, Middle, Last): Vernon Horton
18. Mother's Name (First, Middle, Maiden Surname): Loistine Maxey

19a. Informant's Name/Relationship (Type, Print): Mrs. Loistine Maxey (mother)
19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): 1635 N. Warwick Ave. Balto. Md. 21216

20e. Mathod of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Nama of cemetary, cramatory or othar piece): Greenmount Crematory
Data: 2/5/01
20c. Location - City or Town, Stete: Balto. Md.

21. Signature of Funeral Service Licensee: Joseph L. Russ
22. Name end Address of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

Physician /Medical Examiner

23a. Part I. Entar the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or haart failure. List only one ceuse on eech line.

Approximete Intarval Batween Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in daeth)
a. ETHANOL AND MIXED DRUG INTOXICATION
Due to (or es a consequence of):
b.
Due to (or es e consequence of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of causa of deeth? 1☒ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Menner of Deeth: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☑ Pending investigetion 6☒ Could not be determined
28a. Deta of Injury (Month, Day Year): found:1-28-01
28b. Time of Injury: found: 2:13 PM
28c. Injury et Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: UNKNOWN
28e. Piece of Injury - At homa, farm, street, factory, office building, etc. (Specify): found: vacant building
28f. Location (Street and Number or Rurel Route Number, City or Town, Stata): 1513 Mosher St. Baltimore, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end dua to tha ceusa(s) end menner as stated. 2☒ **Medical Examiner:** On tha basis of examination end/or investigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(s) end mennar statad.
29b. Signeture end title of certifier: M.D.
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JAN. 29, 2001
30. Neme end address of person who complated causa of daeth (Item 23a) (Type, Print): Mary G. Ripley M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): FEB 02 2001
32. Registrer's Signeture: G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02662

Harrell Robert

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert A Harrell Jr.

2. Date of Death (Month, Day, Year): February 2, 2001

3. Time of Death: 2:19 AM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 522-52-3507

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 58 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 15 1942

9. Birthplace (State or Foreign Country): Colorado

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Middle River

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 54 Yew Road

10f. Zip Code: 21220

10g. Citizen of What Country?: USA

11. Meritel Status: 1 ☐ Never Married 2 ☒ Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bank Officer

16b. Kind of Business/Industry: AllFirst

17. Father's Neme (First, Middle, Last): Robert A. HArrell Sr.

18. Mother's Neme (First, Middle, Maiden Surname): Alfretta Garner

19a. Informent's Neme/Reletionship (Type, Print): Janice Harrell / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 54 Yew Road Baltimore Md. 21220

20a. Method of Disposition: 1 ☒ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specity)

20b. Pleca of Disposition (Name of cemetery, cremetory or other place): Holly Hill Cemetery Date: 2/5/2001

20c. Location - City or Town, State: Baltimore MD

21. Signature of Funeral Service Licensee: R. Terry Connelly

22. Name and Address of Facility: Connelly Funeral Homeof essex 300 Mace AVe. Baltimore MD 21221

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in death)
a. SEPSIS — 1 DAY

Due to (or as a consequence of):
b. LUNG CANCER — 1 YEAR

Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was en autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end manner es stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: M Chatham

29c. License number: D 107854

29d. Date signed (Month, Day, Year): FEBRUARY 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIE CHATHAM, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Dete filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Bruce G Hoaks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02663

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Norma Frances Herrmann
2. Date of Death: Month Feb. Day 1 Year 2001
3. Time of Death: 3:45 am.

4a. Facility Name (If not institution, give street and number): Carroll Co. Gen. Hospital
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 219-22-3125
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 1, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 245 Chartley Dr.
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Homemaker

17. Father's Name (First, Middle, Last): George Melvin Smith Sr.
18. Mother's Name (First, Middle, Maiden Surname): Josephine Diederich

19a. Informant's Name/Relationship (Type, Print): Anthony R. Herrmann Jr. - husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 245 Chartley Dr. Reisterstown, Md. 21136

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem.
Date: Feb. 6, 2001
20c. Location - City or Town, State: Owings Mills, Md.

21. Signature of Funeral Service Licensee: ▶ J. Ruth Eckhardt
22. Name and Address of Facility: Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☑ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☑ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D0044362
29d. Date signed (Month, Day, Year): FEBRUARY 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ENRICO A. GIANGERUSO, MD 200 MEMORIAL AVE WESTMINSTER MD

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

HERRMANN, NORMA

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02664

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TATIANA Z HULL
2. Data of Death: Month JAN Day 29 Year 2001
3. Time of Death: 328 Am
4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL
4b. City, Town, or Location of Death: COLUMBIA
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 158-46-7277
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Jan 25, 1915
9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5015 W. Running Brook
10f. Zip Code: 21044
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Reference Librarian
16b. Kind of Business/Industry: Education

17. Father's Name (First, Middle, Last): Ivan Zarudny
18. Mother's Name (First, Middle, Maiden Surname): Lena Brulov

19a. Informant's Name/Relationship (Type, Print): Ms. Mary Hull
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5815 Edson Lane #T-2 Bethesda, MD 20852

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crametory or other place): All County Cremation Services, Inc.
Data: 01/31/01
20c. Location - City or Town, State: Sykesville, Maryland

21. Signature of Funeral Service Licensee: M00535
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPTIC SHOCK — 6 HOURS

Due to (or as a consequence of): b. MESENTERIC ARTERY INFARCT

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): c. ATRIAL FIBRILLATION

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PULMONARY HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D39629
29d. Date signed (Month, Day, Year): JAN 29 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A SY MD 10724 LITTLE PATUXENT PKWY COLUMBIA MD 21044

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02665

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
CURTIS	D.	JACKSON, JR.	FEBRUARY 01 2001	1:30 PM M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
CHESAPEAKE HOSPICE HOUSE	LINTHICUM	ANNE ARUNDEL CO.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-09-8253	1☒M 2☐F	84 Yrs.			Jan. 04 1917	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Anne Arundel Co.	Pasadena	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
213 Sunglow Road	21122	USA

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6	0	Truck Driver	Mountainside Transport

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Curtis D. Jackson, Sr.	Lillian Bodie

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Thelma E. Jackson (Wife)	213 Sunglow Road, Pasadena, Md. 21122

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Loudon Park Cemetery	2/05/2001	Baltimore, Md.

21. Signature of Funeral Service Licensee: ▶ Richard Pickett

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. CONGESTIVE HEART FAILURE	8 yr.
Due to (or as a consequence of):	b. ATHEROSCLEROSIS CORONARY ARTERY DISEASE	9 yr.
Due to (or as a consequence of):	c. CEREBROVASCULAR ACCIDENT	
Due to (or as a consequence of):	d. VENTRICULAR TACHYCARDIA	5 MONTHS

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1☐Yes 2☐No 9☐Unknown	1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) _____ 9☐Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HEAD AND NECK CARCINOMA
SPINAL STENOSIS
CANCER OF PROSTATE

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) HOSPICE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Shobha Reddy MD.	D30568	2·2·01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR. SHOBHA D. REDDY 7845 OAKWOOD RD. Ste 204 Glen Burnie Md. 21061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	▶ Lenora G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02666

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Kelly

2. Date of Death Month Day Year: Jan. 24, 2001

3. Time of Death: 7:30am

4a. Facility Name *(If not institution, give street and number)*: 123 W. 29th Street Apt. #5J

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: NA

Funeral Director

5. Social Security Number: 417-20-6187

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04-23-23

9. Birthplace *(State or Foreign Country)*: FL.

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 123 West 29th Street Apt.5J

10f. Zip Code: 21218

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*

Elementery/Secondery (0-12): 7th Grade

College (1-4or 5+): NA

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ground Maintenance

16b. Kind of Business/Industry: Dept. of Parks & Recreation

17. Father's Neme *(First, Middle, Last)*: Ed Kelly

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Mamie Pigford

19a. Informant's Name/Reletionship *(Type, Print)*: Adrienne Kelly

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1211 N. Bond Street Baltimore, MD 21213

20a. Method of Disposition: XI ☒ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or othar place)*: Woodlawn Cemetery

Dete: 02-03-01

20c. Location - City or Town, Stete: Woodlawn, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Nama and Address of Facility: Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Batween Onset end Death

Immediate Cause (Final disease or condition resulting in deeth): a. Diabetes

Due to (or es a consequence of): b. Hypertension

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Due to (or as a consequence of): c.

Dua to (or as a consequence of): d.

Part II. **Other signifiсant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 ☐ No

25. Wes case referred to medicel exeminer? 1 ☒ Yes 2 ☐ No

26. Place of Deeth *(Check only one)*: Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Othar *(Specify)*

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: ▶ [signature] MD

29c. Licensa number: D52294

29d. Dete signed *(Month, Day, Year)*: 1/26/01

30. Name and address of parson who completed ceuse of death (Item 23a) (Type, Print): COLIN OTTEY / 301 ST. PAUL PLACE SUITE 715, BALT MD 21202

State Registrar

31. Dete filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02667

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ben Kammeier

2. Date of Death — Month: January, Day: 31, Year: 01

3. Time of Death: 1350

4a. Facility Name *(If not institution, give street end number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: N/A

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 0 Yrs. — If Under 1 Year: Months 0, Days 0; If Under 24 Hrs.: Hours 0, Min. 51

8. Date of Birth *(Month, Day, Year)*: January 31, 01

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 106 Market St.

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: John Frederick Kammeier

18. Mother's Name *(First, Middle, Maiden Surname)*: Carolyn Diane Phillips

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn Kammeier/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 106 Market St, Annapolis, MD 21401

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 02/02 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PREMATURITY - PULMONARY HYPOPLASIA

Due to (or as a consequence of):

b. PREMATURE RUPTURE OF MEMBRANES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: N/A

28b. Time of Injury: N/A M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N/A

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: N/A

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] M.D.

29c. License number: D38148

29d. Date signed *(Month, Day, Year)*: JANUARY 31, 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barbara Tyntkiw, MD. 2001 Medical Pkwy, Annapolis, Md. 21401

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02668

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Adam KAMMEIER

2. Date of Death Month / Day / Year: January 31 01

3. Time of Death: 1345

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: N/A

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 0 Yrs. If Under 1 Year: Months 0 Days 0 If Under 24 Hrs.: Hours 1 Min. 7

8. Date of Birth *(Month, Day, Year)*: January 31, 01

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 106 Market St.

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: John Frederick KAMMEIER

18. Mother's Name *(First, Middle, Maiden Surname)*: Carolyn Diane Phillips

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn Kammeier/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 106 Market St. Annapolis, Md. 21401

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 02/02 2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PREMATURITY - PULMONARY HYPOPLASIA

Due to (or as a consequence of):

b. PREMATURE RUPTURE OF MEMBRANES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*: N/A

28b. Time of Injury: N/A M

28c. Injury at Work? N/A 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N/A

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: N/A

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D38148

29d. Date signed *(Month, Day, Year)*: JANUARY 31, 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Barbara Tyuk, MD 2001 Medical Pkwy. Annapolis, Md. 21401

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02669

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Louise Marie Koerner

2. Date of Death Month Day Year: January 29, 2001

3. Time of Death: 1:40 PM

4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-10-2333

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 27, 1910

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3712 West Watersville Road

10f. Zip Code: 21771

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): I

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Conrad M. Ludwig

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth M. Schmidt

19a. Informant's Name/Relationship *(Type, Print)*: E. Stanley Koerner / son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3712 West Watersville Road, Mt. Airy, Maryland 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery

Date: 2/2/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: R A [illegible]

22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. altzeimers disease — 7 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] MD

29c. License number: D0029571

29d. Date signed *(Month, Day, Year)*: 1/29/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Paul Berez MD 1655 Crofton Blvd Suite 101 Crofton, MD 21114

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: [illegible] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02670

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Annabell W. Lewis

2. Data of Death — Month: January Day: 30 Yaar: 2001

3. Time of Death: 8:00 AM

4a. Facility Name *(If not institution, give street and number)*: 5504 Lynview Ave.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 577-42-5448

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Year)*: May 7, 1927

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Rasidanca of Decedant

10a. Stata: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 5504 Lynview Ave.

10f. Zip Code: 21215

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Food Service

16b. Kind of Businass/Industry: Nursing Home

17. Fathar's Nama *(First, Middla, Last)*: William Webster Sr.

18. Mother's Nama *(First, Middla, Maiden Surnama)*: Natchel McGriffin

19a. Informant's Name/Ralationship *(Type, Print)*: Ms. Cassandra Lewis (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 4224 Loch Raven Blvd. Balto. Md. 21218

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematery, crematory or othar placa)*: Fairview Cemetery

Data: 2/6/2001

20c. Location - City or Town, Stata: Staunton, Virginia

21. Signatura of Funaral Sarvica Licansee: Joseph L. Russ

22. Nama and Addrass of Facility: Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused tha death. Do not entar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each line.

Approximata Intarval Between Onset and Death

Immediata Causa (Finel disaasa or condition resulting in daath)

a. Diabetes Mellitus

Dua to (or as a consequanca of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Cause (Disaase or Injury that initiated evants resulting in daath) Last

b. Hypertension

Due to (or as a consequence of):

c. Hypercholesterolemia

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings available prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☑ Yas 2☐ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☑ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28e. Data of Injury *(Month, Day Year)*

28f. Location *(Streat and Number or Rural Route Number, City or Town, Stata)*

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at tha time, date and placa, and dua to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha time, data end place, end due to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: M.D

29c. Licansa number: D16109

29d. Date signed *(Month, Day, Year)*: 1-30-01

30. Nama and address of parson who completed causa of death (Item 23a) (Type, Print): REGINALD O. CROSEY MD 1235 E. Monumout St Balto Md 21202

State Registrar

31. Data filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02671

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM LILLEY
2. Date of Death (Month, Day, Year): January 31, 2001
3. Time of Death: 6:08 PM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Medical Center
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-10-0992
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 3, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Dundalk
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1615 Lynch Road
10f. Zip Code: 21222
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Datas: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Raws Unloader
16b. Kind of Business/Industry: Lever Brother, Corp.

17. Father's Name (First, Middle, Last): William Lilley
18. Mother's Name (First, Middle, Maiden Surname): Alma Jones

19a. Informant's Name/Relationship (Type, Print): Mrs. Frances G. Lilley (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1615 Lynch Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem. — Date: 2/3/2001
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregory E. Reed
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	2 DAYS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Anne Hamik MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANNE HAMIK - JOHNS HOPKINS BAYVIEW MEDICAL CENTER 4940 EASTERN AVENUE, BALTIMORE, MD 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

19A-B
AMEND ITEM: #10A-F G792 2-27-01 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02672

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Burton Lang

2. Date of Death: Month Jan Day 30 Year 2001

3. Time of Death: 1:45pm

4a. Facility Name (If not institution, give street and number): Charlestown Care Center

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-07-4109

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 10, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: BALTIMORE ~~Anne Arundel~~

10c. City, Town or Location: CATONSVILLE ~~Linthicum~~

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 709 MAIDEN CHOICE LANE ~~308 N. Hammonds Fery Road~~

10f. Zip Code: 21228 ~~21090~~

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 11
College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Master Electrician

16b. Kind of Business/Industry: Electrician

17. Father's Name (First, Middle, Last): Herman A. Lang

18. Mother's Name (First, Middle, Maiden Surname): Eleanor Holiday

19a. Informant's Neme/Reletionship (Type, Print): Linda M. Lamm / DAUGHTER

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 Hammonds ~~Fery~~ FERRY Road, Linthicum, MD 21090

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other piece): Loudon Park Cemetery

Date: 2/2/01

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Lani Holland

22. Neme end Address of Fecility: Loudon Park Funeral Home, 3620 Wilkens Avenue Baltimore, Maryland 21229

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. End Stage Dementia — Years

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician**: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and menner es stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Asher Salazar MD

29c. License number: D51051

29d. Date signed (Month, Day, Year): January 30, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andres Salazar 711 Maiden choice lane, Catonsville, MD, 21228

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: Frederick B. LANG

AB-4

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02673

6 1pm

Mowl, Dorothy February 1, 2001

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Dorothy Louise Mowl	Feb. 1, 2001	6:10 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Hospice	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-01-5296	1☐ M 2☒ F	78 Yrs.			Feb. 24, 1922	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Boring	1☐ Yes 2☒ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4201 Osborne Rd	21020	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Giva Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Lawrence C. Brilhart	Elizabeth McAllister

19a. Informent's Name/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
David Mowl / son	419 Weatherby Ave., Swedesboro, NJ 08085

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetary, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Evergreen Memorial Gardens	2/3/01	Finksburg, MD

21. Signature of Funeral Service Licensee	22. Nama and Address of Facility
▶ Laura C. Hardesty	CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Towson, MD 21286

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in deeth)
a. Pancreatic cancer — months

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Last
b.
Dua to (or as a consequence of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case refarred to medical examinar?	26. Place of Death (Check only one)	
1☐ Yas 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D0051926	Feb 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helen M. Gordon MD 6565 N. Charles St, Baltimore MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	▶ Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02674

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROY MCCOY

2. Date of Death Month: JAN Day: 29 Year: 2001

3. Time of Death: 10:45 PM

4a. Facility Name *(If not institution, give street and number)*: ST. AGNES HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 237-14-3558

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 80 Yrs. If Under 1 Yaar: Months / Deys. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 03, 1920

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usuel Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE CITY

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 1821 MORELAND AVENUE

10f. Zip Code: 21216

10g. Citizen of What Country?: USA.

11. Marital Status: 1☐Never Marriad 2☒Merried 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2☒No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- It Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Rece - American Indien, Bleck, Whita, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grada completed)*: Elementery/Secondery (0-12): UNKNOWN; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done duning most of working life. DO NOT use retired)*: MUSICIAN / SALESMAN

16b. Kind of Business/Industry: SEARS ROEBUCK & Co.

17. Father's Name *(First, Middle, Last)*: FRANK RHOADS

18. Mother's Name *(First, Middle, Maiden Surneme)*: HANNAH ELIZABETH BRANAMAN

19a. Intorment's Neme/Reletionship *(Type, Print)*: REGINA McCOY (WIFE)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1821 MORELAND AVENUE, BALTO. MD. 21216

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Ramoval from Stata 4☐Donation 5☐Other *(Specify)*

20b. Place ot Disposition *(Neme of cemetery, crematory or other piece)*: ARBUTUS CEMETERY Dete: 02-02-01

20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signeture of Funeral Servica Licensee: ▶ Robert H. Allen

22. Neme end Address of Feciliti: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Pert1. Enter the disaese, or complications thet causad the death. Do not enter the moda ot dying, such es cardiec or respiretory errest, shock, or heert tellure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Finel disaese or condition resulting in death): e. PNEUMONIA — 1wk

Due to (or as a consequence ot): STROKE — 1wk

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Last:

b. Due to (or as a consequence ot):

c. Dua to (or es a consequence ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Pert I.: Pulmonary fibrosis; Parkinsons disease

23b. Did tobacco use contributa to the causa of death? 1☐Yas 2☒No 3☐Probably 4☐Unknown

24a. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion ot causa ot death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To tha best of my knowledge, death occurred at tha time, dete end plece, end due to the ceuse(s) and menner as stated. 2☐**Medical Examiner**: On the besis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner steted.

29b. Signatura and title of certifier: ▶ Barbaran

29c. Licanse number: D 21649

29d. Date signed *(Month, Day, Year)*: JAN 31 2001

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): SAMBANDAM BASKARAN 3455 Wilkens Ave. Baltimore MD 21229

State Registrar

31. Date filed *(Month, Dey, Year)*: FEB 02 2001

32. Registrer's Signeture: ▶ Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

NAME ROY MCCOY

Pg 1 of 2

IRVINE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02675

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ROBERT R. MATTHEWS, SR.

2. Date of Death — Month: January Day: 31 Year: 2001

3. Time of Death: 5:26 AM

4a Facility Name (If not institution, give street end number): STELLA MARIS HOSPICE AT MERCY

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-30-6060

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthdey) Yrs.: | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min.

8. Date of Birth (Month, Day, Year): July 24 1934

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stste: Md.

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1269 Riverside Ave.

10f. Zip Code: 21230

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Edcetion (Specify only highest grade completed)
Elementery/Secondary (0-12): 10
College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Plumbing

16b. Kind of Business/Industry: Calvert Plumbing

17. Father's Name (First, Middle, Last): George Matthews

18. Mother's Name (First, Middle, Maiden Sumeme): Helen Gauss

19a. Informant's Name/Relationship (Type, Print): June M. Matthews (Wife)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1269 Riverside Ave. Baltimore, Md. 21230

20e. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Green Mount Cemetery

Date: 2/02/2001

20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: George M Hampton Jr.

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 130 E. Fort Ave. Baltimore, Md. 21230

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia — 2 weeks

Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Stroke

Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of desth? 1 [ ] Yes 2 [X] No

25. Wss cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): Hospice

27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion snd/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D38675

29d. Date signed (Month, Dey, Year): 2/1/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202

State Registrar

31. Date filed (Month, Dey, Year): FEB 02 2001

32. Registrar's Signature: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02676

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY M. MOSES

2. Date of Death Month / Day / Year: JANUARY 31 2001

3. Time of Death: 12:23 PM

4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 214-18-3023

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb.09 1923

9. Birthplace *(State or Foreign Country)*: Poland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel Co.

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7601 Beaver Road

10f. Zip Code: 21060

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondary (0-12): 11; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Home Owner

17. Father's Name *(First, Middle, Last)*: Daniel Pirgodich

18. Mother's Name *(First, Middle, Maiden Surname)*: Barbara unknown

19a. Informant's Name/Relationship *(Type, Print)*: Charles Moses (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7601 Beaver Road, Glen Burnie, Md. 21060

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Holy Trinity Russian Cemt.

Date: 2/03/2001

20c. Location - City or Town, State: Elkridge, Md.

21. Signature of Funeral Service Licensee: Frank S. Polyniak

22. Name and Address of Facility: McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Finai diseasa or condition resulting in death)

a. CARDIOGENIC SHOCK — TWO DAYS

Due to (or as a consaquence of):

b. BACTEREMIA — TWO DAYS

Sequanfially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury *(Month, Day Year)*

28b. Time of Injury M

28c. injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sumeet Sawhney . M.D.

29c. License number: P-14121

29d. Date signed *(Month, Day, Year)*: JANUARY 31 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SUMEET SAWHNEY . HARBOR HOSPITAL CENTER ,

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02677

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELEANOR MARGARET MUESSIG
2. Date of Death (Month, Day, Year): February 2, 2001
3. Time of Death: 12:15 AM
4a. Facility Name (If not institution, give street and number): Long Green Nursing Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 165-20-9839
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 18, 1918
9. Birthplace (State or Foreign Country): Pa.

Usual Residence of Decedent

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7103 York Rd.
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker
16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): John Costello
18. Mother's Name (First, Middle, Maiden Surname): Grace Knorr

19a. Informant's Name/Relationship (Type, Print): Patricia Kallmyer/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7103 York Rd. Baltimore, Md. 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other piece): Memorial Shrine Park
Date: 2/9/01
20c. Location - City or Town, State: Wyoming, Pa.

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Urosepsis — days
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Senile dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D17118
29d. Date signed (Month, Day, Year): Feb 2, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Schwartz MD 7105 York Rd 21204

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02678

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
LORRAINE MARGARET MILLS	FEB. 1, 2001	4:45 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GILCHRIST CENTER FOR HOSPICE	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-36-9981	1☐ M 2☒ F	60 Yrs.			Apr. 2, 1940	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	N/A	BALTIMORE	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1250 GLYNDON AVENUE	21223	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		HOUSEWIFE	DOMESTIC

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
MORRIS DAVIS	ANNABELLE CLARK

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MARIE M. VOLD/ SISTER	4220 BRISTOL DR., JAMESVILLE, WI 53546

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MOST HOLY REDEEMER	2/3/01	BALTIMORE, MD.

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility: LILLY & ZEILER INC. FUNERAL HOME, 1901 EASTERN AVENUE, BALTIMORE, MD. 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. lung cancer	months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

rheumatoid arthritis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Helen M Gordon MD	D51926	2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 6565 N. Charles St Baltimore MD 21204 Helen M. Gordon MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Lorraine Mills Feb 1 2001 4:45 AM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02679

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Meligakos
2. Date of Death (Month, Day, Year): JANUARY 28 2001
3. Time of Death: 5:07 P.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-54-6716
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 15, 1934
9. Birthplace (State or Foreign Country): Greece

Usual Residence of Decedant

10a. State: Md.
10b. County: Baltimore
10c. City, Town or Location: Parkville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3 Dakin Court,
10f. Zip Coda: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Restaurant/Self Employed
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Alexandros Meligakos
18. Mother's Name (First, Middle, Maiden Surname): Katerina Karamerou

19a. Informant's Name/Relationship (Type, Print): Anna Meligakos / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 3 Dakin Court, Parkville, Md. 21234

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): OakLawn Cemetery
Date: 2-1-2001
20c. Location - City or Town, State: Balto., Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Rd., Balto., Md. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Myocardial Infarction — 5 minutes
Due to (or as a consequence of):
b. Coronary artery disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] P/A
29c. License number: D0028949
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PANAYIOTIS BALTATZIS, MD. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature] B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

MELAGARIS, JAMES

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02680

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL MUSOTTO

2. Date of Death: Month January Day 30 Year 2001

3. Time of Death: 10:50 pm

4a. Facility Name (If not institution, give street and number): FUTURE CARE CANTON HARBOR

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: n/a

Funeral Director

5. Social Security Number: 215-32-7114

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-14-1904

9. Birthplace (State or Foreign Country): Italy

Usual Residence of Decedent

10a. State: MD

10b. County: n/a

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 623 S. Kenwood Avenue

10f. Zip Code: 21224

10g. Citizen of What Country: USA

11. Meritel Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elamentary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Shoe repair

16b. Kind of Business/Industry: self employed

17. Father's Name (First, Middle, Last): Santo Musotto

18. Mother's Name (First, Middle, Maiden Surname): Domenica Farinella

19a. Informant's Name/Relationship (Type, Print): son Santo Musotto

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 Crosby Rd., Baltimore, Maryland 21228

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Gardens of Faith

Date: 2/3/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: ▶ Marcia B. Zannino

22. Name and Address of Facility: Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St., Baltimore, Maryland 21224

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one causa on each lina.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arrhythmia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

b. Arterio Sclerotic Vascular Disease — Yrs

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism, Dementia

Osteoarthritis,

Cancer Prostate

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: ▶

29c. License number: D24276

29d. Date signed (Month, Day, Year): 1-30-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SIMON SCALIA 2901 FOSTER AVE. BALTIMORE, MD. 21224

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signeture: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02681

Nichols, Roosevelt January 29 2001 2 49 PM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Roosevelt	Nichols	Jan. 29, 2001	2:40am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Gilchrist Hospice Center	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
250-54-3637	XX 1 M 2 F	66 Yrs.			04-08-34	SC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	XX 1 Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1522 N. Patterson Park Avenue	21213	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 XX Married 3 Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes XX No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th Grade	NA	Roofer	Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rhodus Nichols	Modena Gayles

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213
Mary Nichols	1522 N. Patterson Park Ave. Baltimore, MD

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, cramatory or other place)	Date	20c. Location - City or Town, State
XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	King Mem. Pk. Cem.	02-03-01	Randallstown, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Gladys Warner	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North A venue

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. prostate Cancer	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Coronary Artery disease

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No 3 Probably XX Unknown	1 Yes XX No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one) HOSPICE	
1 Yas XX No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence XX 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 XX Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 XX **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley	D25205	January 29, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

W. A. Riley GBMC 6701 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	▶ Gladys Warner

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 12 PER F.H. G792 2-12-01 WR. *Certificate of Death* Reg. No. 2001 02682

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clarence Nazelrod
2. Date of Death Month/Day/Year: JANUARY 29 2001
3. Time of Death: 1740
4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 219-32-5599
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 1, 1936
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Ellicott City
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4245 Montgomery Rd.
10f. Zip Code: 21043
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No
If Yes, Give Year or Dates: 1955 -1961
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief Dep. Clerk / Circuit Court
16b. Kind of Business/Industry: Howard Co. Circiut Court

17. Father's Name *(First, Middle, Last)*: Harold L. Nazelrod, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Ozella Lawson

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Dorothy Nazelrod
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4245 Montgomery Rd. Ellicott City, Maryland 21043

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. John Evangelical Lutheran
Date: 02/03/01
20c. Location - City or Town, State: Columbia, Maryland

21. Signature of Funeral Service Licensee: [signature] MD0535
22. Name and Address of Facility: Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Interstitial lung disease	3 years
Due to (or as a consequence of): b.	renal failure	7 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: RES 000
29d. Date signed *(Month, Day, Year)*: January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TODD Pulerwitz 600 North Wolfe Street, Baltimore, Maryland 21287

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

93-14

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02683

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): THOMAS OGLE
2. Date of Death: Month 01 Day 30 Year 2001
3. Time of Death: 11:42P
4a. Facility Name (If not institution, give street and number): University of Maryland Medical System
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 219-30-1377
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 66 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 16 1934
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location: Essex
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 325 Nicholson Road
10f. Zip Code: 21221
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): / College (1-4or 5+): 4yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Baltimore County

17. Father's Name (First, Middle, Last): John G Ogle
18. Mother's Name (First, Middle, Maiden Surname): Dorthea Hoppert

19a. Informent's Name/Reletionship (Type, Print): Kathleen Ogle / wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 325 Nicholson Road Baltimore Md. 21221

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith
Date: 2/3/2001
20c. Location - City or Town, State: Rossville MD

21. Signature of Funeral Service Licensee: ▶ R. Terry Connelly
22. Name and Address of Facility: Connelly Funeral Home of Essex 300 MAce AVe. Baltimore Md. 21221

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Acute Leukemia
Due to (or as a consequence of): b. Sepsis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. Renal Failure
Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☐Netural 2☐Accident 3☐Suicide 4☐Homicide 5☒Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Jolene Brown MD
29c. License number: P13365
29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jolene Brown MD 22 South Greene Street, Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: ▶ [signature]

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0509-510

MAGGIE PETERSON

AMEND ITEM: 19A PER F.H. G791 2-2-01 WR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02684

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
MAGGIE	PETERSON	JANUARY	30,	2001	8:31 P.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHOCK TRAUMA CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs, last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-24-1476	1☐ M 2☒ F	69 Yrs.					JUNE 18, 1931	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	N/A	BALTIMORE CITY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
515 WARNER ST. APT. B	21230	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11TH GRADE		HOUSEWIFE	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
SAMUEL PETERSON	JANIE DUKES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
NAOMI ~~PETERSON~~ PATTERSON (SISTER)	422 ELDON ROAD, BALTIMORE, MD. 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MT. CALVARY CEMETERY	02-06-01	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Luther A. Miller	JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE, MD. 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	1/30/01	2008 PM	1☐ Yes 2☒ No	Subject pedestrian struck by vehicle

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
roadway	Martin Luther King & Washington Boulevard Baltimore Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King MD	O.C.M.E.	JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02685

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth L. Phillips
2. Date of Death Month Day Year: January 30, 2001
3. Time of Death: 4:45 AM
4a. Facility Name *(If not institution, give street and number)*: Mariner Health at North Arundel
4b. City, Town, or Location of Death: Glen Burnie
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 220-20-3639
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 5, 1923
9. Birthplace *(State or Foreign Country)*: W. Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Glen Burnie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 485 Glen Mar Circle
10f. Zip Code: 21061
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Assembly Line Worker
16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: Clarence E. Lee
18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Beatrice Henson

19a. Informant's Name/Relationship *(Type, Print)*: Marsha Shannon/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 224 Mallard Drive Centerville, MD 21617

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Meadowridge Mem. Park — Date: Feb. 3, 2001
20c. Location - City or Town, State: Elkridge, Maryland

21. Signature of Funeral Service Licensee: David E Bowyer
22. Name and Address of Facility: Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. DEMENTIA, MIXED TYPE	14 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DYSPHAGIA; FLEXION CONTRACTURES

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard E Fisher
29c. License number: D02519
29d. Date signed *(Month, Day, Year)*: January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard E Fisher 4710 Pennington Ave 21226

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

OHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02686

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TSILYA PARGAMMANIK
2. Date of Death (Month, Day, Year): JANUARY 30, 2001
3. Time of Death: 9:20 AM
4a. Facility Name (If not institution, give street and number): JEWISH CONVALESCENT & NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 086-76-1731
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 22, 1926
9. Birthplace (State or Foreign Country): UKRAINE

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 7920 SCOTTS LEVEL ROAD
10f. Zip Code: 21208
10g. Citizen of What Country?: UKRAINE

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): NONE; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WORKER
16b. Kind of Business/Industry: FACTORY

17. Father's Name (First, Middle, Last): GERSHON PARGAMANNIK
18. Mother's Name (First, Middle, Maiden Surname): RAKHIL YAMPOLSKYA

19a. Informant's Name/Relationship (Type, Print): RAISA CHIKAUROVA / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 144 PITTSTON CIRCLE - OWINGS MILLS, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEMETERY
Date: 2/2/01
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. MYOCARDIAL INFARCTION — IMMEDIATE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☒ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] M.D.
29c. License number: 15140
29d. Date signed (Month, Day, Year): JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DW Sinsheimer MD 6210 Kelly Ave, Balt, MD 21215

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature] D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02687

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Estelle Mattie Moss Pitt

2. Date of Death (Month, Day, Year): Jan. 29 2001

3. Time of Death: 1955 PM

4a. Facility Name (If not institution, give street and number): St. Agnes Healthcare - 900 Caton Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 241-30-6610

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): December 27, 1921

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Elkridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6391 Rowanberry Drive

10f. Zip Code: 21227

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician

16b. Kind of Business/Industry: Salon

17. Father's Name (First, Middle, Last): Pell Moss-Son

18. Mother's Name (First, Middle, Maiden Surname): Mentie Moss

19a. Informant's Name/Relationship (Type, Print): James Pitt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 357 Valley Stream Road, Severna Park, Maryland 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Pineview Cemetery

Date: 2-3-01

20c. Location - City or Town, State: Rocky Mount, North Carolina

21. Signature of Funeral Service Licensee: Lisa S. Jefferson

22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiac Arrythmia	25 minutes
Due to (or as a consequence of): b.	Congestive Heart Failure	10 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Aortic Stenosis	10 years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: P13594

29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Tom Balsh: St. Agnes Hospital Baltimore MD 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Jennie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME Estelle M. Pitt

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPS
01-0502-510
ARLENE POEHLITZ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02688

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Arlene Courtney-Poehlitz
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 11:27 AM
4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: n/a

Funeral Director

5. Social Security Number: 217-34-3636
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 2, 1937
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Brooklyn Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 458 Seward Avenue
10f. Zip Code: 21225
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Telephone Operator
16b. Kind of Business/Industry: Communication

17. Father's Name *(First, Middle, Last)*: Christian Walter Morsberger
18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Marie Williams

19a. Informent's Name/Reletionship *(Type, Print)*: Cheryl A. Baker / daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3700 Baltimore Street, Baltimore, Maryland 21227

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bayview Crematory
Date: 2/2/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Ann Y. Zink
22. Name and Address of Facility: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Hypertensive Arteriosclerotic Cardiovascular Disease

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequenca of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? Inspection 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient ☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Pestaner, M.D.
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 18 PER F.H. G792 2-2-01 WR.

Certificate of Death

Reg. No. 2001 02689

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Evelyn G. Roberts
2. Date of Death: Month January Day 26 Year 2001
3. Time of Death: 340 AM
4a. Facility Name (If not institution, give street and number): Mariner Health - Bel Air
4b. City, Town, or Location of Death: Bel Air
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-32-0680
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 11, 1903
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5200 Ramblewood Dr #201
10f. Zip Code: 21009
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): James Grafton
18. Mother's Name (First, Middle, Maiden Surname): ~~(Unknown)~~ MINNIE MINNICK

19a. Informant's Name/Relationship (Type, Print): Albert Condit / Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 Briar Hill Place; Essex, MD 21221

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory, Inc | Date: 1/29/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Progressive Dementia — 4 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): NA
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D39889
29d. Date signed (Month, Day, Year): JAN 27, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALFRED SPARKS 615 W. MAPLE HILL BLVD MD 21014

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Roberts, Evelyn

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02690

Rutledge, Malcolm
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MALCOLM N. RUTLEDGE
2. Date of Death Month/Day/Year: JAN 26 2001
3. Time of Death: 0615
4a. Facility Name (If not institution, give street and number): DEATON NURSING HOME
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-80-3915
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 13, 1960
9. Birthplace (State or Foreign Country): MARYLAND

Usuet Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE CITY
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3622 ROCKDALE TERRACE
10f. Zip Code: 21244
10g. Citizen of What Country?: USA.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bieck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10TH GRADE | College (1-4or 5+):
16a. Decedent'a Uauel Occupation (Give kind of work done duning most of working life. DO NOT use retired): SECURITY AGENT
16b. Kind of Business/Industry: WATKINS SECURITY

17. Father'a Name (First, Middle, Last): PAUL RUTLEDGE
18. Mother's Name (First, Middle, Maiden Surneme): VIOLET WELLS

19a. Informent's Name/Reletionship (Type, Print): VIOLET W. RICHARDSON (MOTHER)
19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3622 ROCKDALE TERRACE, BALTO. MD. 21244

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): ARBUTUS CEMETERY
Dete: 02-01-01
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signetura of Funeral Service Licensee:
22. Neme end Address of Feciliti: JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO. MD. 21217

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximete Intervel Between Onset and Death

Immediate Cause (Finat disease or condition resulting in death)
a. CEREBRAL ABSCESS - Pseudoallescheria boydii
Due to (or es e consequence of):
b. MRSA septic arthritis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
Due to (or es e consequence of):
c. depression
Due to (or es e consequenca of):
d. advanced AIDS

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: hepatitis C, seizures, S/P (L) femoral

23b. Did tobacco uss contributs to the causs of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findinga aveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medicat examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospitet: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Deacribe how injury occurred
28e. Ptece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner stated.

29b. Signeture end titte of certifier: MD
29c. License number: D52394
29d. Dete signed (Month, Dey, Year): 1-30-01

30. Neme end eddress of person who completed cauae of deeth (Item 23e) (Type, Print): Ila Mulasi, 295. Greene Street suite #300, Baltimore MD, 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Day, Year): FEB 02 2001
32. Registrer's Signeture:

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02691

RANDAZZO, MARY
Baltimore, Maryland 21215-0036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY RANDAZZO
2. Date of Death: Month JANUARY Day 31 Year 2001
3. Time of Death: 8:20 A.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-28-3661
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 27, 1918
9. Birthplace (State or Foreign Country): ILLINOIS

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: BALTIMORE
10c. City, Town or Location: PARKVILLE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8621 WENDELL AVE.
10f. Zip Code: 21234
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 YRS. College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS
16b. Kind of Business/Industry: CLOTHING + TAYLOR

17. Father's Name (First, Middle, Last): CHARLIE PUZZO
18. Mother's Name (First, Middle, Maiden Surname): MARY BARBAGALLO

19a. Informant's Name/Relationship (Type, Print): JOANNA P. WARFIELD
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8621 WENDELL AVE. PARKVILLE, MARYLAND 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DULANEY VALLEY MEM. GARDENS
Date: FEB. 3, 2001
20c. Location - City or Town, State: TIMONIUM, MARYLAND
21. Signature of Funeral Service Licensee:
22. Name and Address of Facility: MEMORIES EVANS CHAPEL OF 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. SEPTICEMIA — 4 DAYS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SUBDURAL HEMATOMA;
RESTRICTIVE LUNG DISEASE
SCOLIOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Marco Zamora MD
29c. License number: D40819
29d. Date signed (Month, Day, Year): January 31, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARCO ZAMORA, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: Jeanne B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02692

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELIZABETH SARAH REINHARDT
2. Date of Death Month Day Year: JAN 30 2001
3. Time of Death: 16:41

4a. Facility Name *(If not institution, give street and number)*: ERLUPPER CHESAPEAKE MED CTR
4b. City, Town, or Location of Death: BELAIR
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 213-05-5535
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct. 20, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Street
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3812 Prospect Road
10f. Zip Code: 21154
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 Years; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Teamsters Union

17. Father's Name *(First, Middle, Last)*: John Wenker
18. Mother's Name *(First, Middle, Maiden Surname)*: Caroline Not Known

19a. Informant's Name/Relationship *(Type, Print)*: Betty A. Harris (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3812 Prospect Road Street, Maryland 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sacred Heart of Jesus Cem.
Date: 2/2/2001
20c. Location - City or Town, State: Dundalk, MD

21. Signature of Funeral Service Licensee: Stephanie Massey
22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JAN 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPNABHN MD 728 BELAIR MD 21014 4108796564

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02693

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dolores Rodman
2. Date of Death: Month January, Day 27, Year 2001
3. Time of Death: 1:38 am
4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 352-09-0331A
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Jan. 30, 1918
9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Odenton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 518 Gladhill Road
10f. Zip Code: 21113
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Robert James O'Brien
18. Mother's Name (First, Middle, Maiden Surname): Bernadine Taylor

19a. Informant's Name/Relationship (Type, Print): Lawrence M. Vincent (POA)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1607 Myamby Road, Baltimore, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: 2/1 2001
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Patrick J. Hardesty
22. Name and Address of Facility: Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARRYTHMIA - Atrial Fibrillation — 2-4 DAYS

Due to (or as a consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. COPD

Due to (or as a consequence of):
d. MALNUTRITION

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DEHYDRATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes ☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Priesh I. Kumar
29c. License number: D0055556
29d. Date signed (Month, Day, Year): JANUARY 28, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PRIESH I. KUMAR, M.D., 64 FRANKIN ST, ANNAPOLIS, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0506-005

MICHAEL SHRADER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 23a,27,28a-f per ME G793 SS

Certificate of Death

Reg. No. 2001 02694

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL R. SHRADER

2. Date of Death Month / Day / Year: JANUARY 30, 2001

3. Time of Death: 1:35P.M.

4a. Facility Name *(If not institution, give street and number)*: 544 COMPASS ROAD

4b. City, Town, or Location of Death: MIDDLE RIVER

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 212-52-4460

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 50 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG 30, 1950

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: BALTIMORE

10c. City, Town or Location: MIDDLE RIVER

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 544 COMPASS ROAD

10f. Zip Code: 21220

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 YRS. / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: INSTALLER

16b. Kind of Business/Industry: C+P. TELEPHONE COMPANY

17. Father's Name *(First, Middle, Last)*: RICHARD J. SHRADER

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH L. HERRMANN

19a. Informant's Name/Relationship *(Type, Print)*: ELIZABETH L. SHRADER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8820 WALTHER BLVD. APT. 4412 PARKVILLE, MARYLAND 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: MARYLAND MEMORIAL PARK

Date: FEB 2 2001

20c. Location - City or Town, State: PARKVILLE, MARYLAND

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD PARKVILLE, MARYLAND 21234

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury *(Month, Day Year)*: found: 1-30-01

28b. Time of Injury: found: 1:35 PM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: residence

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 544 Compass Rd., Middle River, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ Theodore M. King MD

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JANUARY 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature ▶ Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02695

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Skleres , Jr.

2. Date of Death (Month, Day, Year): January 30, 2001

3. Time of Death: 8:07 a.m.

4a. Facility Name (If not institution, give street and number): 8543 Morven Road

4b. City, Town, or Location of Death: Parkville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-22-0117

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 02/03/1929

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Parkville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 8543 Morven Road

10f. Zip Code: 21234

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Parts Division

16b. Kind of Business/Industry: General Motors

17. Father's Name (First, Middle, Last): John Skleres

18. Mother's Name (First, Middle, Maiden Surname): Ethel Vlangas

19a. Informant's Name/Relationship (Type, Print): Mr. Rick Spivey/son-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2525 Girdwood Road Timonium, MD 21093

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Greek Orthodox Cemetery

Date: 02/02/2001

20c. Location - City or Town, State: Woodlawn, Maryland

21. Signature of Funeral Service Licensee: Stephen D. Coster M01122

22. Name and Address of Facility: Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardio Resp Arrest	acute
Due to (or as a consequence of):	b. HASCVD post C.A.B.G 93	10yr
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Megakaryocytic Leukemia 11/00

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D07132

29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD MAFFEZZOLI, MD 515 FAIRMOUNT AVE TOWSON, MD 21286

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

B-1041

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 29D PER PHY G791 2-2-01 WR. *Certificate of Death*

Reg. No. 2001 02696

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): OSWALD VICTOR VOIGT

2. Date of Death: Month JANUARY Day 28 Year 2001

3. Time of Death: 12:20 PM

4a. Facility Name (If not institution, give street and number): 359 BIGLEY AVENUE

4b. City, Town, or Location of Death: LANSDOWNE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 213-28-1778

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 20, 1931

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Lansdowne

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 359 Bigley Ave.

10f. Zip Code: 21227

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1952-1953

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Research

16b. Kind of Business/Industry: Navy

17. Father's Name (First, Middle, Last): Oswald Voight

18. Mother's Name (First, Middle, Maiden Surname): Bessie Haur

19a. Informant's Name/Reletionship (Type, Print): Bethann Kuhle, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26300 Clancy St. Roseville, MI 48066

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Loudon Park Cemetery

Date: 2-1-01

20c. Location - City or Town, State: Baltimore, MD

21. Signeture of Funeral Service Licensee: Rebecca Robinson

22. Name and Address of Facility: Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 21227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:

b. Due to (or as e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [illegible]

29c. License number: D11171

29d. Date signed (Month, Day, Year): FEBRUARY 2, 2001 ~~JANUARY~~ 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 405 FREDERICK ROAD CATONSVILLE MARYLAND 21228

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: Lewis B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RJD
ALVIN WOLS
01-494-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEMS# 23a,b,ptII & 27 per ME G792 022701 SS

Certificate of Death

Reg. No. 2001 02697

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month, Day, Year)	3. Time of Death
ALVIN	A.	WOLF	JANUARY 30, 2001	0035 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SINAI HOSPITAL	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-12-8032 A	X 1 M 2 F	78 Yrs.			SEP. 4,1922	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	BALTIMORE	1 Yes 2 X No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2 EDEN ROC COURT	21208	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	1 X Yes 2 No WWII	1 Yes 2 X No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		PROPRIETOR	BOND LUMBER COMPANY

17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)	
MORRIS	WOLF	ROSE	POLSKY

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RITA M. WOLF / WIFE	2 EDEN ROC COURT - BALTIMORE, MD 21208

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	BETH YEHUDA ANSHE KURLAND	2/1/01	BALTIMORE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):
HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE ASSOCIATED WITH PANCREATITIS AND RECENT BILIARY SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 No	1 Yes 2 No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	O.C.M.E.	JANUARY 30, 2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Dennis Clarke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 02 2001	▶ [signature] G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02698

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Josephine Elaine Wagner

2. Date of Death — Month: January Day: 31 Year: 2001

3. Time of Death: 12:15 AM

4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center

4b. City, Town, or Location of Death: Rosedale

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-22-5578

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 17, 1915

9. Birthplace (State or Foreign Country): Washington

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2915 Dunmurry Road Apt. B

10f. Zip Code: 21222

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Retail Sales

17. Father's Name (First, Middle, Last): Glenn Percy Fox

18. Mother's Name (First, Middle, Maiden Surname): Blanche Matheny

19a. Informant's Name/Relationship (Type, Print): Virginia A. Meding (Sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7016 B Mornington Road Dundalk, Maryland 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Meadowridge Mem. Park Cem. — Date: 2/2/2001

20c. Location - City or Town, State: Dorsey, Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	1 Week
Due to (or as a consequence of): b.	Cerebrovascular Accident	2 Months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Stuart Ackerman D.O.

29c. License number: RD198796

29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Stuart Ackerman 9000 Franklin Square Drive Baltimore, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: ▶ [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Wagner, Josephine

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02699

AMENDED ITEM #20b per fh G792 020201 SS

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death (Month, Day, Year)	3. Time of Death
James	Waller	Jan. 30, 2001	09:35am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Universtity Hospital	Baltimore	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yeer: Months	If Under 1 Yeer: Days	If Under 24 Hrs.: Hours	If Under 24 Hrs.: Min.	8. Dete of Birth (Month, Day, Yeer)	9. Birthplece (State or Foraign Country)
215-40-9893	1☒ M 2☐ F	55 Yrs.					03-13-45	MD

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Insida City Limits
MD	NA	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Cltizen of Whet Country?
1533 Homestead S reet	21218	USA

11. Marital Status	12. Wes Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced	☒☒ Yes 2☐ No If Yes, Giva Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use ratired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12th Grade	NA	Driver	MD. Messenger Ser.

17. Fathar's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Milton Waller	Selena Boyd

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Evelyn Waller	1533 Homestead Street Baltimore, MD 21218

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, crematory or other piece)	Date	20c. Location - City or Town, Stete
1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)	King Mem. Pk. Cem.	02-06-01 ~~02-05-01~~	Randallstown, MD

21. Signeture of Funerel Service Licensee	22. Name and Address of Facility
▶ A Lady Wane	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final disease or condition resulting in deeth)	a. Cardiac Arrest	30 mins
	Due to (or es a consequence of):	
Sequentielly list conditions, if any, leeding to Immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest	b. Uncontrolled Hypertension	6 mos
	Due to (or es a consequence of):	
	c. Diabetes Mellitus	10 years
	Dua to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yaa 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings availeble prior to completion of causa of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Piece of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death	28a. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) and menner as stated.
2☐ **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ Andya Hault DO	P14751	01/30/01

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)
University of Maryland 22 S. Greene St. Baltimore, MD 21201-1595

State Registrar

31. Data filed (Month, Day, Year)	32. Registrer's Signeture
FEB 08 2001	▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02700

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Mae Wylie

2. Date of Death Month: JAN Day: 31, Year: 2001

3. Time of Death: 3:25 PM

4a. Facility Name *(If not institution, give street and number)*: 3039 Brighton St.

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 244-34-7347

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 20, 1915

9. Birthplace *(State or Foreign Country)*: NC

Usual Residence of Decedent

10a. State: NC

10b. County: Stanly

10c. City, Town or Location: Badin

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 321 Grant St.

10f. Zip Code: 28009

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Home maker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Cleveland Lindsey

18. Mother's Name *(First, Middle, Maiden Surname)*: Della Smith

19a. Informant's Name/Relationship *(Type, Print)*: Roosevelt Lindsey/Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3039 Brighton St. Baltimore, MD 21216

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: Bessie Chapel Amezion Church Cemetery

Date: FEB 4, 2001

20c. Location - City or Town, Stete: Lilesville, NC

21. Signature of Funeral Service Licensee: Daniel Simons

22. Name and Address of Facility: Smith Funeral Home 604 Salisbury St. Wadesboro, NC 28170

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Sepsis	1 day
Due to (or as a consequence of): b.	Peritonitis	7 days
Sequentially list conditions, if any, leading to immediete ceuse. Enter Underlying Ceuse (Disese or injury that initiated events resulting in deeth) Last — Due to (or as e consequence of): c.	Colon cancer	5 years
Due to (or es e consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Brother's Res.

27. Menner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred et the time, date and place, end due to the cause(s) and mennar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, In *my* opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier

29c. License number: D0056070

29d. Date signed *(Month, Day, Year)*: 2/1/01

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): Eric Nuermberger, MD Rm 9017, 1830 E. Monument St. Baltimore, MD 21205

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Geneva G Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02701

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen A. Witt
2. Date of Death (Month, Day, Year): January 30, 2001
3. Time of Death: 8:55 PM
4a. Facility Name *(If not institution, give street and number)*: Future Care
4b. City, Town, or Location of Death: Arnold
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-01-3735
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: September 26, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Pasadena
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 112 Bar Harbor Road
10f. Zip Code: 21122
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Claims Adjuster
16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Joseph Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Helen Magsamen

19a. Informant's Name/Relationship *(Type, Print)*: Ernest Witt-Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 112 Bar Harbor Road, Pasadena, Maryland 21122

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Loudon Park Cemetery
Date: 2-2-2002
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Lisa S. Jefferson
22. Name and Address of Facility: Loudon Park Funeral Home, 3620 Wilkens Avenue, Baltimore, Maryland 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Primary Biliary Cirrhosis — 3 years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John F. Loome, MD
29c. License number: D52728
29d. Date signed *(Month, Day, Year)*: January 31, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Loome, M.D. 479 Jumpers Hole Road #304 Severna Park, MD 21146

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001
32. Registrar's Signature: Serena G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02702

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GERALDINE YOWELL

2. Date of Death — Month: FEBRUARY Day: 1 Year: 2001

3. Time of Death: 9:15AM

4a. Facility Name *(If not institution, give street and number)*: HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 263-38-6246

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept. 19, 1929

9. Birthplace *(State or Foreign Country)*: Florida

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3097 Fleetwood Avenue

10f. Zip Code: 21216

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietician

16b. Kind of Business/Industry: Food Service

17. Father's Name *(First, Middle, Last)*: Florence E. Leonardy

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Lee Hogan

19a. Informant's Name/Relationship *(Type, Print)*: Virginia Lee Huber / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3097 Fleetwood Avenue, Baltimore Maryland 21230

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Cemetery

Date: February 3, 2001

20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr.

22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RENAL FAILURE — 2 DAYS

Due to (or as a consequence of):

b. SEPSIS — 3 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Guillermo Giangreco, MD

29c. License number: RES 001

29d. Date signed *(Month, Day, Year)*: FEBRUARY 1 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GUILLERMO JOSE GIANGRECO HARBOR HOSPITAL CENTER

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 02 2001

32. Registrar's Signature: Jennie G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02703

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sister Mary Teresa Yingling

2. Date of Death: Month January Day 27 Year 2001

3. Time of Death: 5:10 A.M.

4a. Facility Name (If not institution, give street and number): The Villa 6806 Bellona Avenue

4b. City, Town, or Location of Death: Rodgers Forge

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-54-8301

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01 27 1920

9. Birthplace (State or Foreign Country): Wash. D.C.

Usual Residence of Decedent

10a. Stete: MD

10b. County: Baltimore

10c. City, Town or Location: Rodgers Forge

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6806 Bellona Avenue

10f. Zip Code: 21212

10g. Citizen of Whet Country?: USA

11. Merital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher/ Religious Vocation

16b. Kind of Business/Industry: Sisters of Mercy

17. Father's Name (First, Middle, Last): Matthew Yingling

18. Mother's Name (First, Middle, Maiden Surneme): Louise C. Harrington

19a. Informant's Neme/Relationship (Type, Print): Sr. Monica McKinley

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 6806 Bellona Ave. Baltimore, MD 21212

20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Woodlawn Cemetery

Date: 01/30/01

20c. Location - City or Town, Stete: Baltimore, MD

21. Signature of Funeral Servica Licensee: ▶ Robert J Padacz

22. Neme and Address of Facility: Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Finet disease or condition resulting in death)

a. Endometrial carcinoma — 2½ years

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that intiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other signifcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contributa to the causa of death? 1☐ Yea 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicat examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Cartifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end mannar as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: ▶ Marc Sokolow MD Attending Physician

29c. License number: D26534

29d. Date signed (Month, Day, Year): 2/1/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Marc Sokolow, MD 301 St. Paul Place Baltimore, MD 21202

State Registrar

31. Date filed (Month, Day, Year): FEB 02 2001

32. Registrar's Signature: ▶ [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02704

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bernard Anderson

2. Date of Death Month / Day / Year: JAN. 14th 01

3. Time of Death: 10:25 A.M.

4e. Facility Name *(If not institution, give street and number)*: SPRING BROOK REHABILITATION CENTER

4b. City, Town, or Location of Death: SILVER SPRING MD.

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 227-12-2439

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 31, 1919

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 524 E. Indian Spring Drive

10f. Zip Code: 20901

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired

16b. Kind of Business/Industry: Government

17. Father's Name *(First, Middle, Last)*: Frank Anderson

18. Mother's Name *(First, Middle, Maiden Surname)*: Burcenia Fountain

19a. Informant's Name/Relationship *(Type, Print)*: Lucille Anderson/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 524 E. Indian Spring Drive, Silver Spring, Md. 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BIG HILL BAPT. CHURCH CEM.

Date: 1-20-10

20c. Location - City or Town, State: SALEM, VA.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Johnson & Jenkins Inc. 716 Kennedy St., N.W Wash. D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic Renal carcinoma

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Anaemia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kieti Vohra M.D

29c. License number: D-20274

29d. Date signed *(Month, Day, Year)*: 1/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KIETI VOHIA 12325 NEW HAMPSHIRE AVE. SILVER SPRING, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

(10)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02705

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Beatrice	Stern	Applebee	January	13,	2001	11:00 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hebrew Home of Greater Washington	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
066-07-5057	1☐ M 2☒ F	86 Yrs.					June 16, 1914	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Olney	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
18121 Marksman Circle #403	20832	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yas 2☒ No If Yes, Giva Yeer or Detes:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grada completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12	4	Substitute Teacher	Montgomery Co. Schools

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
Philip Stern	Lena Pfeffer

19a. Informent's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Scott M. Applebee (Son)	3012 O'Hara Place Olney, Maryland 20832

20a. Method of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or othar piece)	Date: January 19, 2001	20c. Location - City or Town, Stata
1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)	Lee Crematory		Clinton, Maryland

21. Signeture of Funerel Service Licensee	22. Neme end Address of Facility
▶ Charles L. Bilanger	Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Pert1. Enter tha disease, or complications thet ceused the death. Do not enter the moda of dying, such es cerdiec or respiratory arrest, shock, or heart tailure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediata Causa (Finel diseese or condition resulting in deeth)

a. RENAL FAILURE — MONTHS

Due to (or as a consequence ot):

b. CITRONIC MYELOGENOUS LEUKEMIA — YEARS

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

Due to (or as e consequence ot):

c.

Due to (or as e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

HYPERTENSION

HYPOTHYROIDISM

CHRONIC CEREBRAL ISCHEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	N/A 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer?	26. Place of Deeth (Check only one)	
1☐ Yas 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28a. Dete ot Injury (Month, Dey Yeer)	28b. Time ot Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece ot Injury - At home, term, street, tectory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis ot examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner statad.

29b. Signetura and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Steven Lipson	D 5885	01/13/01

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print)

STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE

State Registrar

31. Date filed (Month, Day, Year)	32. Registrer's Signeture
JAN 17 2001	▶ Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02706

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS O. ALUODO

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 4:45 pm

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-25-0506

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 20, 1959

9. Birthplace *(State or Foreign Country)*: Kenya

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7808 Polara Place

10f. Zip Code: 20855

10g. Citizen of What Country?: Kenya

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): | College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Agriculturalist

16b. Kind of Business/Industry: Agriculture

17. Father's Name *(First, Middle, Last)*: Dalmas Aluodo

18. Mother's Name *(First, Middle, Maiden Surname)*: Teresa Ngere

19a. Informant's Name/Relationship *(Type, Print)*: Onyango E. Nyunja /Brother-in-law

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7808 Polara Place, Rockville, MD 20855

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Awasi, Wangaya 1, Kenya

Date: Jan 22 2001

20c. Location - City or Town, State: Nyando District, Kenya

21. Signature of Funeral Service Licensee: John C. Parker

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Fulminant Sepsis — weeks

Due to (or as a consequence of):

b. Brain Tumor — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Terminal AIDS — years

Due to (or as a consequence of):

d. Pneumonia — weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Efobi, Anthony U-MD

29c. License number: D 048144

29d. Date signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony Efobi, MD 9901 Medical Center Drive, Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02707

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lucie Ann Abell

2. Date of Death (Month, Day, Year): January 28, 2001

3. Time of Death: 6:00 AM

4a. Facility Name (If not institution, give street and number): 28095 Old Village Road

4b. City, Town, or Location of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 578-03-9001

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 20, 1912

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 28095 Old Village Road

10f. Zip Code: 20659

10g. Citizen of What Country? U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12th grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Paul Waldron Dunbar

18. Mother's Name (First, Middle, Maiden Surname): Lucy May Beale

19a. Informant's Name/Relationship (Type, Print): Diane Delahay (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 451, Leonardtown, Maryland 20650

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Aloysius Cemetery

Date: 2/1/2001

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Edward M. Brinsfield, JR M00052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia (Bilateral)

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CVA Recurrent

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Right Breast

severe internal carotid artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D19917

29d. Date signed (Month, Day, Year): 1/30/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): James Boyd, MD California, Maryland 20619

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02708

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beatrice Theresa Aud

2. Date of Death Month Day Year: JANUARY 14, 2001

3. Time of Death: 3:42PM

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-24-0576

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 1, 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Leonardtown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 20677 Chingville Road

10f. Zip Code: 20650

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John Henry Pilkerton

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Lillian Quade

19a. Informant's Name/Relationship *(Type, Print)*: Joseph Reginald Aud (Spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20677 Chingville Road, Leonardtown, Maryland 20650

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charles Memorial Gardens

Date: 1/17/01

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael Kevin Hardiman

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. COPD — 4 weeks

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Zahir Yousaf MD

29c. License number: D0027189

29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. ZAHIR YOUSAF PRINCE FREDERICK, MD. 20678

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME: BEATRICE THERESA AUD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02709

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Robert Stephan Adams

2. Date of Death Month Day Year: JANUARY 15, 2001

3. Time of Death: 8:59AM

4a. Facility Neme *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-28-1497

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 14, 1933

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Hollywood

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 45089 Smith Nursery Road

10f. Zip Code: 20636

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondery (0-12); College (1-4or 5+): 2 Yrs.

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Store Owner

16b. Kind of Business/Industry: Retail Store

17. Father's Neme *(First, Middle, Last)*: Lee Blanford Adams

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Louise Callis

19a. Interment's Neme/Relationship *(Type, Print)*: Rose Elizabeth Adams (Spouse)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 45089 Smith Nursery Road, Hollywood, Maryland 20636

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: St. John's Cemetery

Date: 1/19/01

20c. Location - City or Town, State: Hollywood, Maryland

21. Signeture of Funerel Service Licensee: Michael Kevin Gardiner

22. Name end Address of Feciliity: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)

a. Carcinomatosis — wks.

Due to (or as a consequence of):

b. Lung Cancer — 6 mo.

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: James Jarboe MD

29c. License number: D 0649

29d. Date signed *(Month, Day, Year)*: 1-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JAMES JARBOE HOLLYWOOD, MD. 20636

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 17 2001

32. Registrer's Signeture: G. Mowbray

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

NAME: ROBERT ADAMS

15/[illegible]

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02710

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHIRLEY ANN ANGLE

2. Date of Death Month Day Year: JANUARY 22 2001

3. Time of Death: 9:05 PM

4a. Facility Name *(If not institution, give street and number)*: 3 BEDROCK CIRCLE

4b. City, Town, or Location of Death: KEEDYSVILLE

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 220-64-2147

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 20, 1954

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: KEEDYSVILLE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3 BEDROCK CIRCLE

10f. Zip Code: 21756

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: LICENSED PRACTICAL NURSE

16b. Kind of Business/Industry: DOCTOR'S OFFICE

17. Father's Name *(First, Middle, Last)*: ELMER WAYNE KEPHART

18. Mother's Nama *(First, Middle, Maiden Sumame)*: LILLIAN L. ROHRER

19a. Informant's Name/Relationship *(Type, Print)*: GERALD M. ANGLE/SPOUSE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3 BEDROCK CIRCLE, KEEDYSVILLE, MARYLAND 21756

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cematary, crematory or other place)*: BOONSBORO CEMETERY

Date: 1/25/01

20c. Location - City or Town, State: BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that ceused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death)

a. Carcinoma of breast — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case rafarred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician**: To tha best of my knowledge, death occurred at the tima, data and place, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Frederick H Kass MD

29c. License number: D23623

29d. Data signed *(Month, Day, Year)*: January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Frederick Kass, M.D. 11110 Medical Campus Road, Hagerstown, Maryland 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signatura: Donna P Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02711

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALMA MAE AMICK

2. Date of Death (Month, Day, Year): JANUARY 23, 2001

3. Time of Death: 3:35 AM

4a. Facility Name (If not institution, give street and number): RAVENWOOD LUTHERAN VILLAGE

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 232-38-3648

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): Feb. 4, 1917

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Washington Co.

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11723 Peacock Trail

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☒ Never Married 2☐ Merried 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Caregiver

16b. Kind of Business/Industry: Private Home

17. Father's Neme (First, Middle, Last): Sherman Guy Amick

18. Mother's Name (First, Middle, Maiden Surneme): Stella Mae Hanks

19a. Informant's Neme/Reletionship (Type, Print): Irma R. Mowry, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11723 Peacock Trail, Hagerstown, Maryland 21742

20a. Method ot Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): Carson Valley Cemetery

Dete: Jan.30

20c. Location - City or Town, Stete: Duncansville, PA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address ot Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DEMENTIA — 5 years

Due to (or as a consequence ot):

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — 5 years

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence ot):

c. Probable Pneumonia — 2 DAYS

Due to (or as a consequence ot):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place ot Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner ot Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date ot Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best ot my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) end manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title ot certifier: [signature]

29c. License number: D28365

29d. Date signed (Month, Day, Year): 1-23-01

30. Name and address ot person who completed cause of death (Item 23a) (Type, Print): MANZAR JSHAFI 368 Mill Street Hagerstown MD 21740.

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AMICK, Alma Mae

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02712

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Virginia Brown

2. Date of Death (Month, Day, Year): January 11, 2001

3. Time of Death: 6:15AM

4a. Facility Name *(If not institution, give street and number)*: 5219 Morris Avenue Apt. 105

4b. City, Town, or Location of Death: Camp Springs

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 224-24-2441

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: March 13, 1921

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Rasidence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Camp Springs

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Streat and Number: 5219 Morris Avenue Apt 105

10f. Zip Coda: 20746

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retirad)*: Silk Finisher

16b. Kind of Business/Industry: Dry Cleaner

17. Fathar's Nama *(First, Middla, Last)*: Robert Brooks

18. Mother's Nama *(First, Middle, Maidan Surnama)*: Janie Reynolds

19a. Informant's Name/Reletionship *(Type, Print)*: Lafayette Brown (Husband)

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5219 Morris Avenue Apt. 105 Camp Springs, MD20746

20a. Mathod of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Lee Crematory

Date: January 12, 2001

20c. Location - City or Town, Stata: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haart faitura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Finat disaasa or condition resulting in death)

a. Metastatic Colon Cancer — 2 Months

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequanca of):

d.

Part tt. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Residence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 8☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At homa, farm, street, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: MD057546-L (PA)

29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and addrass of person who complatad causa of daath (Item 23a) (Type, Print): Robert B. Donegan, MAJ, USAFMC Hematologist/Oneologist AAFB MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signatura: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

DHMH 16 Rev 6/95

ORIGINAL

00-0122-033
jhm
DARNELL
PRITT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02713

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DARNELL LAMONT BRITT
2. Date of Death (Month, Day, Year): JANUARY 08, 2001
3. Time of Death: 00:18 AM
4a. Facility Name (If not institution, give street and number): 7734 MUNCY ROAD
4b. City, Town, or Location of Death: LANDOVER
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 214-86-0630
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 29 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb.27,1971
9. Birthplace (State or Foreign Country): Wash., DC

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince George's
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 2121 Alice Avenue #101
10f. Zip Code: 20745
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mover
16b. Kind of Business/Industry: Hauling

17. Father's Name (First, Middle, Last): Leon T. Britt
18. Mother's Name (First, Middle, Meiden Surname): Barbara McClurkin

19a. Informant's Name/Relationship (Type, Print): Evelyn L. Britt / Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 2121 Alice Ave. #101 Oxon Hill, Md. 20745

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 1-16-01
20c. Location - City or Town, State: Landover, Md.

21. Signature of Funeral Service Licensee: Larry Coffell
22. Name and Address of Facility: Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple shotgun and gunshot wounds

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 X Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 ☐ No

25. Was case referred to medical examiner? 1 X Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) SCENE

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1-08-2001
28b. Time of Injury: 0014 M
28c. Injury at Work? 1 ☐ Yes 2 X No
28d. Describe how injury occurred: Subject was shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Sidewalk
28f. Location (Street and Number or Rural Route Number, City or Town, State): 7734 Muncy Road Prince Georges County, Maryland

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 08, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02714

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALICE STOKES BOLDEN
2. Date of Death: Month JAN Day 9 Year 2001
3. Time of Death: 4:30 AM
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 228-42-6257
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JANUARY 13, 1923
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGE'S
10c. City, Town or Location: LAUREL
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9001 CHERRY LANE
10f. Zip Code: 20708
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): BUS DRIVER
16b. Kind of Business/Industry: SCHOOL SYSTEM

17. Father's Name (First, Middle, Last): ALBERT STOKES
18. Mother's Name (First, Middle, Maiden Surname): HANNAH TABB

19a. Informant's Name/Relationship (Type, Print): BRENDA BOLDEN, DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7519 NEWBERRY LANE, LANHAM, MD 20706

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): GLOUCESTER FIELD | Date: 9-JAN 2001
20c. Location - City or Town, State: ORDINARY, VA

21. Signature of Funeral Service Licensee: Helen E Green
22. Name and Address of Facility: GREENE FUNERAL HOME 814 FRANKLIN ST. ALEXANDRIA, VA 22314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST — 4 hours

Due to (or as a consequence of):
b. ORGANIC BRAIN SYNDROME

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Margolis M.D.
29c. License number: D 25430
29d. Date signed (Month, Day, Year): 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN MARGOLIS M.D. 13952 BALTIMORE AVE. LAUREL, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: Bernice G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02715

HOWARD S. BAUSERMAN - JANUARY 16, 2001
Baltimore, Maryland 21215-0036 @ 6:45 AM

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Howard Shank Bauserman	Jan. 16, 2001	6:45 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hospice of Baltimore at Gilchrist Center	Towson	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
234-01-9243	1☒ M 2☐ F	88 Yrs.			Oct. 1, 1912	Virginia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Towson	1☐ Yes 2☒ No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6601 North Charles St.	21204	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
7		Machine Tender	Paper Production

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Joseph Bauserman	Ada Shank

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Venice Whittington/ Stepdaughter in-law	5231 Sunnybrook Court, Cape Coral, FL 33904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Wiseburg Cemetery	Jan. 21, 2001	White Hall, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. multi-system failure, secondary	
Due to (or as a consequence of):	b. TO septic shock	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ W. Anthony Riley, MD	D25205	January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
W. A. Riley 6601 N. Charles St. Balto. MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 22 2001	▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, MD 21215-0036

BJ.

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02716

BUDELIS, Louise January 16 2001 5:30 pm

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louise G. Budelis
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 5:30 PM
4a. Facility Name (If not institution, give street and number): Gilchrist Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-07-1107
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 25, 1913
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4708 Moravia Road
10f. Zip Code: 21206
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Noeth
18. Mother's Name (First, Middle, Maiden Surname): Caroline Krampe

19a. Informant's Name/Relationship (Type, Print): Margaret M. Forrester (dghtr)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 50 Whips Lane, Baltimore, MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Most Holy Redeemer Cem.
Date: 1/19/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Miller
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart lailure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. multi-infarct dementia — years
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as s consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy lindings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case relerred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, lerm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ W. Anthony Riley, MD
29c. License number: D25205
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W. A. Riley, MD MC 6701 N. Charles St. Balto. MD 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Bal.

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State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02717

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alma R. Bendis

2. Date of Death (Month, Day, Year): January 15 2001

3. Time of Death: 250pm

4a. Facility Name (If not institution, give street and number): Upper Chesapeake Medical Campus

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-28-5550

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 20, 1931

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2916 Old Mountain Road , South

10f. Zip Code: 21085

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: Oil Company

17. Father's Name (First, Middle, Last): Milbert L. Hopkins

18. Mother's Name (First, Middle, Maiden Surname): Josephine Wojcinski

19a. Informant's Name/Relationship (Type, Print): Andrea Bendis-Munday (Dghtr)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 806 Fox Bow Drive, Bel Air, Maryland 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory

Date: 1/22/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Road, Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Bowel — 1 Day

Due to (or as a consequence of):

b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S. Requena MD

29c. License number: D 53720

29d. Date signed (Month, Day, Year): January 15th 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S Requena MD, 2112 Belair Rd, #1, Fallston, MD 21047

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ALMA Bendis

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02718

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alta Bernice Byers
2. Date of Death Month / Day / Year: Jan. 21, 2001
3. Time of Death: 12:15pm
4a. Facility Name *(If not institution, give street and number)*: 3724 Rock Run Road
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 305-38-8592
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 06/29/1937
9. Birthplace *(State or Foreign Country)*: Kentucky

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3724 Rock Run Road
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Dates: 1956-57
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Marvin Thompson
18. Mother's Name *(First, Middle, Maiden Surname)*: Maudie Carvin

19a. Informant's Name/Relationship *(Type, Print)*: Gary L. Byers, Jr., Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3724 Rock Run Rd., Havre De Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harford Memorial Grdns.
Date: 1/25/01
20c. Location - City or Town, State: Aberdeen, MD

21. Signature of Funeral Service Licensee: Elaine M. Smith
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COPD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: DME
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JAN 21, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GSPNABHN MD 728 BEARL MD BEARL MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001
32. Registrar's Signature: Donna D. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02719

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Gladys Margurette Bowman

2. Date of Death Month / Day / Year: January 18 2001

3. Time of Death: 11:22PM

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-64-2653

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 25, 1915

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Union Bridge

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 520 Key Heights Rd.

10f. Zip Code: 21791

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 5 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: farm wife

16b. Kind of Business/Industry: dairy

17. Father's Name *(First, Middle, Last)*: Raymond I. Buffington

18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Eyler

19a. Informant's Name/Relationship *(Type, Print)*: David I. Bowman Sr./ son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4065 Bark Hill Rd. Union Bridge, MD 21791

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Pipe Creek Cemetery

Date: 1/20/01

20c. Location - City or Town, State: nr. Linwood, MD

21. Signature of Funeral Service Licensee: Catherine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 6 E. Broadway Union Bridge, MD 21791

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LARGE Right CEREBROVASCULAR ACCIDENT — 3 days

Due to (or as a consequence of):

b. Peripheral Vascular Disease — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: I Thomas K. Galvin III

29c. License number: D31660

29d. Date signed *(Month, Day, Year)*: 1/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS GALVIN III MD 291 STONER AVE. WESTMINSTER, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02720

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph Franklin Burke, Jr.

2. Date of Death Month Day Year: Jan 21, 2001

3. Time of Death: 3:35 pm

4a. Facility Name *(If not institution, give street and number)*: 3821 Shiloh Avenue apt 16

4b. City, Town, or Location of Death: Hampstead

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-07-4822

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 25,1920

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Hampstead

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3821 Shiloh Avenue Apt 16

10f. Zip Code: 21074

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self Employed

16b. Kind of Business/Industry: Salesman

17. Father's Name *(First, Middle, Last)*: Joseph Franklin Burke

18. Mother's Name *(First, Middle, Maiden Surname)*: Viola Ray Rineman

19a. Informant's Name/Relationship *(Type, Print)*: Eva Mae Burke, wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3821 Shiloh Ave, apt 16, Hampstead, MD 21074

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Garrison Forest Vet Cem Date: 01/25/2001

20c. Location - City or Town, State: Owings Mills, MD

21. Signature of Funeral Service Licensee: Steven W Eline M00723

22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, Md 21074

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC PANCREATIC CA — 3 MOS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Flavio Kruter MD

29c. License number: D35392

29d. Date signed *(Month, Day, Year)*: 1-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Flavio Kruter, M.D., 555 South Center Street, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: Geneva B Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02721

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARA ODELL BRIDGES
2. Date of Death Month / Day / Year: JANUARY 17 2001
3. Time of Death: 11:10 AM
4a. Facility Name *(If not institution, give street and number)*: 21180 DOVER BRIDGE RD
4b. City, Town, or Location of Death: PRESTON
4c. County of Death: CAROLINE

Funeral Director

5. Social Security Number: 414-20-6288
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JUNE 3 1919
9. Birthplace *(State or Foreign Country)*: TENNESSEE

Usual Residence of Decedent

10a. State: MD
10b. County: CAROLINE
10c. City, Town or Location: PRESTON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21180 DOVER BRIDGE RD
10f. Zip Code: 21655
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: ENOCH E. HUNLEY
18. Mother's Neme *(First, Middle, Maiden Surnama)*: BELL DAUGHERTY

19a. Informant's Neme/Reletionship *(Type, Print)*: CHARLES E. HUNLEY/NEPHEW
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15905 MENK RD., ACCOKEEK, MD 20607

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: SPRING HILL CEMETERY
Date: 1-20-01
20c. Location - City or Town, Stata: EASTON, MD

21. Signature of Funeral Service Licensee: ▶ Joseph M Ostrowski
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — 1 hour
Due to (or as a consequence of):
b. Coronary Artery Disease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.
History of Pulmonary Embolus
Type II Diabetes Mellitus

23b. Did tobacco uss contributs to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☒ No

25. Was cese referred to medicat examiner? 1☐ Yes 2☒ No
26. Plece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ Carolyn Helmly MD
29c. License number: D0053602
29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): CAROLYN HELMLY M.D. 606 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signatura: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

CLARA BRIDGES
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02722

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eleanor Bill

2. Date of Death: Month Jan, Day 23, Year 2001

3. Time of Death: 6:35 PM

4a. Facility Name (If not institution, give street and number): Caroline Nursing Home

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 138-52-4020

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Aug 09 1910

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: Easton

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 306 Maple Ave.

10f. Zip Code: 21601

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 08; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Neme (First, Middle, Last): John Quillan

18. Mother's Neme (First, Middle, Maiden Surname): Ellen Pilkington Quillan

19a. Inlorment's Neme/Reletionship (Type, Print): Edward S. Bill/ son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 306 Maple Ave. Easton, Maryland 21601

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Bethel Cemetery

Date: 01/27

20c. Location - City or Town, State: Hurffville, N.J.

21. Signeture of Funeral Servica Licensee: ▶ [signature]

22. Neme end Address of Facility: Fleegle-Helfenbein Funeral Home, P.A. P.O. Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Final diseese or condition resulting in death)

a. Pneumonia — Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Lest

b. — Due to (or es a consequence of):

c. — Due to (or as a consequence of):

d.

Days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Rectal Cancer

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ James Sides MD

29c. License number: D3137G

29d. Date signed (Month, Day, Year): 01/23/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): James Sides, MD Market Street Denton, Maryland 21629

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001

32. Registrer's Signature: ▶ Renee G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02723

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Dale Buckler, Sr.

2. Date of Death: Month January Day 4, Year 2001

3. Time of Death: 7:00 AM

4a. Facility Name (If not institution, give street and number): 27097 Morganza Turner Road

4b. City, Town, or Location of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-72-9452

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 42 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 7, 1958

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 27097 Morganza Turner Road

10f. Zip Code: 20659

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Bernard L. Buckler

18. Mother's Name (First, Middle, Maiden Surname): Lucy I. Buckler

19a. Informant's Name/Relationship (Type, Print): Veronica A. Buckler (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27097 Morganza Turner Road, Mechanicsville, Maryland 20659

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens

Date: 1/6/01

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael Kevin Gardiner Jr.

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): —

28b. Time of Injury: — M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred: —

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): —

28f. Location (Street and Number or Rural Route Number, City or Town, State): —

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D14285

29d. Date signed (Month, Day, Year): 1-5-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyd, II Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02724

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Lois Joyce BENWAY
2. Date of Death Month / Day / Year: January 19, 2001
3. Time of Death: 1:30 p. m.
4a. Facility Name *(If not institution, give street and number)*: Genesis Elder Care
4b. City, Town, or Location of Death: Brooklyn Park
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 097-20-8186
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 8, 1925
9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 811 Linwood Road
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0-12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: housewife
16b. Kind of Business/Industry: her own home

17. Father's Name *(First, Middle, Last)*: Paul E. Montgomery
18. Mother's Name *(First, Middle, Maiden Surname)*: Petra Alida Peterson

19a. Informant's Name/Relationship *(Type, Print)*: Cheryl P. Poole - daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 17838 Sherman Avenue, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hagerstown Crematory
Date: Jan. 23, 2001
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Fred L. Unate
22. Name and Address of Facility: Minnich Funeral Home, 415 East Wilson Blvd., Hagerstown, Maryland 2174(

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hepatic Failure — 1 month

Due to (or as a consequence of):
b. Cirrhosis — 1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hepatitis C — 20 years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Ascites

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D53462
29d. Date signed *(Month, Day, Year)*: 1/19/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jude Muneses MD 7845 Oakwood Road Glen Burnie MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02725

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ETHEL PAULINE BEALER

2. Date of Death Month: January Day: 22 Year: 2001

3. Time of Death: 0130

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 217-58-3951

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAY 30, 1918

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: ROHRERSVILLE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3325 KAETZEL ROAD

10f. Zip Code: 21779

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: IRA HARRY SHAFER

18. Mother's Name *(First, Middle, Maiden Surname)*: E. BLANCHE ROUTZAHN

19a. Informant's Name/Relationship *(Type, Print)*: ROBERT L. BEALER/SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3261 KAETZEL ROAD, KNOXVILLE, MARYLAND 21758

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: PLEASANT VIEW CEMETERY

Date: 1/25/01

20c. Location - City or Town, State: ROHRERSVILLE, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean

22. Name and Address of Facility: BAST FUNERAL HOME 7606 Old National Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Pneumonia	1 wk
Due to (or as a consequence of):		
b.	Urosepsis	1 wk
Due to (or as a consequence of):		
c.	dehydration	2 wks
Due to (or as a consequence of):		
d.		

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia
Senility
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D44996

29d. Date signed *(Month, Day, Year)*: Jan 22, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zafar Malik MD 20311 Leppos Rd Boonsboro, MD 21713

State Registrar

31. Date Filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Beale, Ethel

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended item# 10e./WCHD/SC 1/25/01

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02726

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death (Month / Day / Year)	3. Time of Death
Katherine	Mary	Browning	Jan. 23 2001	0735

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Loyalton of Hagerstown	Hagerstown	Washington

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-05-2326	1☐ M 2☒ F	87 Yrs.			Jan. 10, 1914	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Washington	Hagerstown	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~201 Carling Ave.~~ 201 Garlinger Ave.	21740	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Detes:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10	-	Clerk	Private Industry

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Roy Karn	Edith Stockslager

19e. Intormant's Neme/Reletionship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Linda L. Perry / Daughter	1191 Avondale Court Frederick, MD 21702

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Rest Haven Cemetery	1/26/01	Hagerstown, MD

21. Signature of Funeral Service Licensee	22. Neme and Address of Facility
▶ [signature]	Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, Md. 21742

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediete Cause (Finet disease or condition resulting in death)	a. Carcinoma liver	2 week
Due to (or as a consequence of):		
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted living Quarters

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certitier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Gloria F. Puca	D 19824	1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GLORIA F PUCA 366 Pine St Hagerstown Md 21740

State Registrar

31. Dete tiled (Month, Day, Year)	32. Registrar's Signature
JAN 24 2001	[signature] D Sparks

To be completed by the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

JAN 5 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02727

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aubrey Bee Breeden

2. Date of Death (Month, Day, Year): January 25, 2001

3. Time of Death: 2:30 p.m.

4a. Facility Name *(If not institution, give street and number)*: 2255 Ward Chapel Road

4b. City, Town, or Location of Death: Owings

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 225 32 9012

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 22, 1929

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Owings

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 2255 Ward Chapel Road

10f. Zip Code: 20736

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1948-50

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Etamantery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working lifa. DO NOT use retired)*: electrician

16b. Kind of Businass/Industry: aviation

17. Fathar's Name *(First, Middle, Last)*: Henry Breeden

18. Mother's Neme *(First, Middle, Maiden Sumame)*: Mary Powell

19a. Informant's Neme/Relationship *(Type, Print)*: Dolores A. Breeden (wife)

19b. Malting Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: same as 10 above

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Ptece of Disposition *(Name of cametery, crematory or other placa)*: Metropolitan Crematory

Dete: 1-28-01

20c. Location - City or Town, Stete: Alexandria, VA

21. Signeture of Funeral Service Licensee: [signature]

22. Nama end Addrass of Fecility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disaesa, or complications that educed the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on aech lina.

Approximate Intarvel Batween Onset and Deeth

Immedieta Cause (Final disease or condition resulting in deeth): a. METASTATIC LUNG CANCER — 3 YEARS

Due to (or es e consequence ot):

Sequentially list conditions, if sny, leeding to immediete cause. Entar Underlying Cause (Disease or Injury that initieted events resulting in death) Last:

b.

Due to (or as e consequance of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case retarred to medical exeminer? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, daath occurred at tha time, data and place, and dua to the cause(s) and mennar stated.

29b. Signeture and title of certifier: [signature] MD

29c. License number: A 36091

29d. Date signed *(Month, Day, Year)*: 1/26/01

30. Name and addrass of person who comploted cause of death (Item 23a) (Type, Print): ANTHONY BOAKYE MA 6104 OLD BRANCH AVE TEMPLE HILLS MD 20748

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 26 2001

32. Registrar's Signetura: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

1 VA

01-0276-009
crn
Christopher P. Blomgren
Amend #4, 216-08-1923, 1/25/2001, drw

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02728

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher Patrick Blomgren
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 1:54 A.M.
4a. Facility Name (If not institution, give street and number): 11507 Ventura Trail
4b. City, Town, or Location of Death: Lusby
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: -unknown- 216-08-1923
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 21 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 22 1979
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Lusby
10d. Inside City Limits: 1☐Yes 2☒No
10a. Street and Number: 11507 Ventura Trail
10f. Zip Code: 20657
10g. Citizen of What Country?: United States

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): construction
16b. Kind of Business/Industry: construction labor

17. Father's Neme (First, Middle, Last): John Keith Blomgren
18. Mother's Name (First, Middle, Maiden Surneme): Dorene Joy Mudd

19a. Informant's Name/Reletionship (Type, Print): Dorene J. Carroll- mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11507 Ventura Trail Lusby, MD 20657

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removel from State 4☐Donation 5☐Other (Specify)
20b. Placa of Disposition (Name of cemetery, cremetory or other placa): Metropolitan Funeral Serive — Date: 1/18/01
20c. Location - City or Town, State: Alexandria Virginia

21. Signature of Funeral Service Licensee: Boden Rausch
22. Name and Address of Facility: Rausch Funeral Home PA 4405 Broomes Is. Rd. Port REpublic MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart teilure. List only one cause on eech line. — Approximate Interval Between Onset and Death: 2 days

Immediate Cause (Final disease or condition resulting in death): a. Hanging
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequenca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? Inspection 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) at scene
27. Manner of Death: 1☐Netural 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Date of Injury (Month, Day Year): Found: 01-17-2001
28b. Time of Injury: Found: 1:45 A M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: Subject hanged self.
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 11507 Ventura Trail, Lusby, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: J Pestaner M.D.
29c. License number: O.C.M.E.
29d. Dete signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrer's Signeture: Jenna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02729

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hazel Berry

2. Date of Death (Month, Day, Year): January 17, 2001

3. Time of Death: 12:25 P.M.

4a. Facility Name (If not institution, give street and number): 9709 5th St. Ridgeview Drive

4b. City, Town, or Location of Death: Owings

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 213-38-2818

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 11, 1939

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Owings

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9709 5th Street Ridgeview Drive

10f. Zip Code: 20736

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Joseph Samuel Gray

18. Mother's Name (First, Middle, Maiden Surname): Eleanor Leana Wills

19e. Informent's Neme/Reletionship (Type, Print): Roxanne Cook/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 282 Owings, MD 20736

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ward's UMC Cemetery

Date: 1/23/01

20c. Location - City or Town, State: Owings, MD

21. Signature of Funeral Service Licensee: ▶ Gladys A. Sewell

22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER — MONTHS

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due fo (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residenca 8☐ Other (Specify)

27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and manner stafed.

29b. Signafure and title of certifier: ▶ John H. Weigel MD

29c. License number: D26358

29d. Date signed (Month, Day, Year): JAN. 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN H. WEIGEL, MD - PRINCE FREDERICK, MD - 20678

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: ▶ Penny D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02730

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLAIRE BARNETT
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 7:15 p.m.
4e. Facility Name (If not institution, give street end number): Calvert County Nursing Center
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 053 01 1703
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 17, 1912
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 85 Hospital Drive
10f. Zip Code: 20678
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper
16b. Kind of Business/Industry: construction

17. Father's Name (First, Middle, Last): Max Boxer
18. Mother's Name (First, Middle, Maiden Surname): Pearl Kriess

19a. Informant's Name/Relationship (Type, Print): Harriett Panos (daughter)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3580 Deep Landing Road, Huntingtown, MD 20639

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Wellwood Cemetery
Date: 1-22-01
20c. Location - City or Town, State: Long Island, New York

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name end Address of Facility: Rausch Funeral Home, P.A. P.O. Box # 100, Owings, MD 20736

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cirdio - Resp arrest

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Recurrent UTI

Due to (or es e consequence of):
c. Dementia

Due to (or as a consequence of):
d. Urosepsis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Endocarditis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. License number: D 50290
29d. Date signed (Month, Day, Year): 1 - 19 - 01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DHIREN SHAH MD 110, HOSP RD, PRINCE FREDRICK MD

State Registrar

31. Dete filed (Month, Day, Year): 1 - 19 - JAN 19 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02731

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BARBARA ALSTON
2. Date of Death: Month JANUARY Day 5 Year 2001
3. Time of Death: 7:45 am
4e. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577 70 9885
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 8, 1951
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: Prince George's
10c. City, Town or Location: CALVERTON
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 12038 Beltsville Drive
10f. Zip Code: 20705
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4 years
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Engineer
16b. Kind of Business/Industry: Private

17. Fether's Name (First, Middle, Last): James Alston
18. Mother's Name (First, Middle, Maiden Surname): Eliza Lee

19a. Informant's Name/Relationship (Type, Print): Ophelia Alston/sister
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 378 Harry S, Truman Dr. Largo, MD 20774

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery | Date: 1-12-01
20c. Location - City or Town, State: Bladensburg, Maryland

21. Signature of Funeral Service Licensee: Kimberly C Buscaccione
22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MD 4308 Suitland Road Suitland, MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC RENAL CANCER — 18 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptaca of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: MD
29c. License number: 041715
29d. Date signed (Month, Day, Year): 1.5.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHIRA VENKATA RAMAN MD 6201 GREENBELT ROAD #3 COLLEGE PARK MD 20740

State Registrar

31. Date filed (Month, Dey, Year): JAN 16 2001
32. Registrer's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the etending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02732

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAMELA BANKS
2. Date of Death Month: 1 Day: 11 Year: 2001
3. Time of Death: 9:42 PM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 240-04-1136
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 42 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1958
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 804 Richmond Avenue
10f. Zip Code: 20910
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Science
16b. Kind of Business/Industry: Educational

17. Father's Name (First, Middle, Last): Jesse J. Banks, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Ruby Helen Penny

19a. Informant's Name/Relationship (Type, Print): Jesse J. Banks, Jr. Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 Kitt Place, Raleigh, NC 27610

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 1/16/01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ André Thompson
22. Name and Address of Facility: McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. STROKE — HOURS
Due to (or as e consequence of):
b. RIGHT PONS BLEED — HOURS
Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
SARCOIDOSIS. HYPERCHOLESTEROLEMIA.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: ▶ Hugo G Graziani MD
29c. License number: D0 81 88
29d. Date signed (Month, Dey, Year): 1-12-2001

30. Neme end address of person who completed ceuse of death (Item 23a) (Type, Print): HUGO G GRAZIANI MD 717 PERSHING DRIVE SILVER SPRING MD 20910

State Registrar

31. Dete filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signature: ▶ Bonnie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0226-031
mjnmr
Unknown 01-011
Miguel Angel Perez-Barrios

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02733

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Miguel Angel Perez Barrios
2. Date of Death Month Day Year: January 13, 2001
3. Time of Death: 2344 pm
4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number:
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 22 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8-6-78
9. Birthplace *(State or Foraign Country)*: Mexico

Usual Rasidence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9036 Centerway Rd
10f. Zip Code: 20879
10g. Citizen of What Country?: Mexico

11. Merital Status: ☒☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: Mexican
14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elemantary/Secondary (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpet Installer
16b. Kind of Business/Industry: Commercial

17. Father's Name *(First, Middle, Last)*: Enrique Perez Rivera
18. Mother's Nama *(First, Middle, Maiden Surname)*: Maria Isabel Barrios

19a. Informant's Name/Relationship *(Type, Print)*: Rocio Perez Barrios
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 28 N Summit Dr Gaithersburg Md 20877

20a. Method of Disposition: ☒☒ 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, cremetory or other piece)*: Tetela Morelos Cem
Date: 1-23-01
20c. Location - City or Town, State: Morelos Mexico

21. Signature of Funeral Service Licensee: Roger J Mann
22. Name and Address of Facility: Sterling Funeral Service 1601 Kenilworth Ave NE Wash DC 20019

CR

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Intarval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. STAB WOUND OF CHEST

Due to (or as a consequence of):

Sequantiellly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco usa contributa to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Wara autopsy findings available prior to completion of cause ot death? 1☒ Yes 2☐ No

25. Was case referred to medicat examiner? ☒☒ 1 Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient ☒☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: 1/13/01 FOUND
28b. Time of Injury FOUND: 2319 M
28c. Injury at Work? 1☐ Yas 2☒ No
28d. Describe how injury occurred: SUBJECT WAS STABBED
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: A RESIDENCE
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*: 324A E. DIAMOND AVE, GAITHERSBURG, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the tima, data and place, and due to the causa(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at the tima, data and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 14, 2001

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Bonnie G. Sparks

(2)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02734

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George E. Boisse
2. Date of Death Month Day Year: January 18, 2001
3. Time of Death: 7:21 PM
4a. Facility Name *(If not institution, give street and number)*: Ft. Washington Hospital
4b. City, Town, or Location of Death: Ft. Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 006-14-5953
6. Sex: 1☐M 2☐F XX
7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 1, 1925
9. Birthplace *(State or Foreign Country)*: Maine

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 103 Kerby Hill Road
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? XX☐Yes 2☐No If Yes, Give Year or Dates: 1942-1948
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Business/Industry: PEPCO

17. Father's Name *(First, Middle, Last)*: Doris Oscar Boisse
18. Mother's Name *(First, Middle, Maiden Surname)*: Celina Forest

19a. Informant's Name/Relationship *(Type, Print)*: Maria C. Boisse / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 103 Kerby Hill Road Ft. Washington, Maryland 20744

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem.
Date: 01/29/2001
20c. Location - City or Town, State: Cheltenham, MD.

21. Signature of Funeral Service Licensee: ▶ Geo. P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home 6160 Oxon Hill Road, Oxon Hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE Lung Disease — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ William T. Tanner
29c. License number: D35206
29d. Date signed *(Month, Day, Year)*: January 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William T. Tanner, MD 11701 Livingston Rd. Ft. Washington, Maryland 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02735

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Esther Virginia Bynum
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 6:50 PM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 578-42-3261
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Sept. 24, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedant

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2750 Middletown Road
10f. Zip Coda: 20603
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No — If Yes, Give Yaar or Dates: X
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yas 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: African American

15. Decedant's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Household Technician
16b. Kind of Business/Industry: Self Employed

17. Fathar's Name (First, Middle, Last): Zeller Berry
18. Mother's Name (First, Middle, Maiden Surname): Edith Freeland

19a. Informant's Name/Relationship (Type, Print): Juliette V. Countiss (Daug.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5031 Preston Ln. (Pomfret, Md. 20675)

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans
Data: 1/25/01
20c. Location - City or Town, State: Cheltenham, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Stewart Funeral Home, Inc. 4001 Benning Rd., N.E. (Wash., D.C. 20019)

To Be Completed by Funeral Director

Esther V Bynum
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enlar tha disaasa, or complications that caused the daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. breast cancer with metastasis
Due to (or as a consequence of):
b. dehydration
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive heart failure
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Othar (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D-0022574
29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert T. Pace, M.D. 12070 Old Line Center, Suite 202 Waldorf, MD 20602

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: ▶ Jennifer D. Sparks

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02736

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Brown
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 9:30pm
4a. Facility Name (If not institution, give street and number): Magnolia Nursing HOme
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 098-20-8931
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 30, 1918
9. Birthplace (State or Foreign Country): Rembert, Nc

6 1/5

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5003 Apache ST
10f. Zip Code: 20740
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Labratory Assistant
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Charles Manigault
18. Mother's Name (First, Middle, Maiden Surname): Sallie Dixon

19a. Informant's Name/Relationship (Type, Print): Barbara Alston / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5003 Apache St, College Park, Md 20740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem
Date: 1-18-01
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: [signature] M0083
22. Name and Address of Facility: Alexander S. Pope Funeral Home, 11315 Lockwood Drive, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Hypertensive Cardiomyopathy	20 yrs
Due to (or as a consequence of): b.	Diabetes Mellitus	25 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease

Failure to thrive

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D30111
29d. Date signed (Month, Day, Year): January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary W. Jones MD 4214 Colonel Ewell Ct Upper Marlboro Md 20772

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: [signature] S. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02737

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HELEN W. BLAKE
2. Date of Death Month: 01 Day: 13 Year: 2001
3. Time of Death: 12:05pm
4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-12-7695
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 12, 1913
9. Birthplace *(State or Foreign Country)*: Leesburg, Va.

Usual Residence of Decedent

10a. State: DC
10b. County: N/A
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 623 Keefer Pl. N.W.
10f. Zip Code: 20010
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk Typist
16b. Kind of Business/Industry: HEW

17. Father's Name *(First, Middle, Last)*: James Thorton
18. Mother's Name *(First, Middle, Meiden Sumeme)*: Mary Frances Thorton

19a. Informant's Neme/Reletionship *(Type, Print)*: Sharon Williams/Granddaughter
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2419 Mary Pl. Ft. Washington, MD. 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: Solon Cemetery
Date: 1-20-01
20c. Location - City or Town, State: Middleburg, Va.

21. Signature of Funeral Service Licensee: J. P. Marshall
22. Name and Address of Feciility: Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington, D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — 4 days

Due to (or as e consequence of):
b. Urinary tract infection AND

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. infected decubitus ulcers

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.
Coronary Artery disease
Diabetes mellitus

23b. Did tobacco use contributa to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: Deidra L. Turner, MD
29c. License number: D33512
29d. Date signed *(Month, Day, Year)*: 1/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deidra L. TURNER, MD; 11701 Livingston Rd, Ste 101; Ft. Washington, Md 20744

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 19 2001
32. Registrer's Signeture: pending G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02738

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BARBARA J. BRIGGS
2. Date of Death (Month, Day, Year): JANUARY 16, 2001
3. Time of Death: 9:15 AM
4a. Facility Name *(If not institution, give street and number)*: 11937 Bambi Court
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-25-6565
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 53 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan.24,1947
9. Birthplace *(State or Foreign Country)*: S. Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 11937 Bambi Court
10f. Zip Code: 20878
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grede completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home

17. Fathar's Nama *(First, Middla, Last)*: Rava Ware
18. Mothar's Name *(First, Middle, Maiden Surnama)*: Susie Keels

19a. Informant's Name/Retationship *(Type, Print)*: Sylvia Briggs (Daughter)
19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, State, Zip Code)*: 11937 Bambi Ct., Gaithersburg, MD 20878

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetary, crametory or other piece)*: George Washington Cem
Date: 1/20/01
20c. Location - City or Town, State: Adelphi, MD

21. Signature of Funeral Service Licensee: Lance R. Snowden SR
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

Approximata Intarval Batween Onset and Death

Immediate Cause (Finai disease or condition resulting in death): a. Diabetes Mellitus

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequance of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying causa given in Part t.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, end due to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D18726
29d. Date signed *(Month, Day, Year)*: Jan. 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Arthur Schoengold, M.D. 18111 Prince Philip Dr., Olney, MD 20832

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signatura: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02739

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE R. CRAWFORD
2. Date of Death Month / Day / Year: 1 / 18 / 2001
3. Time of Death:
4a. Facility Name *(If not institution, give street and number)*: ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 305-03-7383
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7-29-13
9. Birthplace *(State or Foreign Country)*: OHIO

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: OCEAN PINES
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 131 PINEHURST RD.
10f. Zip Code: 21811
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DIRECTOR OF SALES
16b. Kind of Business/Industry: FINANCE

17. Father's Name *(First, Middle, Last)*: HARRY B. CRAWFORD
18. Mother's Name *(First, Middle, Maiden Surname)*: LORETTA JENNINGS

19a. Informant's Name/Relationship *(Type, Print)*: CECILIA C. CRAWFORD
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 131 PINEHURST RD. OCEAN PINES, MD. 21811

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MARYLAND VETS. CEM.
Date: 1-22
20c. Location - City or Town, State: HURLOCK, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD. 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive heart failure
Due to (or as a consequence of):
b. Acute myocardial infarction
Due to (or as a consequence of):
c. Atherosclerotic cardiovascular disease
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Aortic stenosis
Gastrointestinal hemorrhage, acute

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of Certifier: [signature] MD
29c. License number: D0055906
29d. Date signed *(Month, Day, Year)*: 01/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LUCY B. VAN VOORHEES, 314 Franklin Ave., BERLIN, MD 21811

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 2 2 2001
32. Registrar's Signature: [signature] B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Crawford, George R 305037383 7/29/13 - 1/18/01

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02740

Chilcoat, George Jr

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
George Rufus Chilcoat, Jr.	JANUARY 16 2001	6:30AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
GREATER BALTIMORE MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-30-9540	1☒ M 2☐ F	69 Yrs.			Jan. 31, 1931	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Baltimore	Parkton	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
17015 York Road	21120	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: Korean	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Expeditor	Concrete Manufacturing

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
George Rufus Chilcoat, Sr.	Gladys M. Tracey

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patricia Chilcoat/Wife	17015 York Rd., Parkton, MD 21120

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	First Baptist Cemetery of Hereford	Jan. 20, 2001	Hereford, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial infarction	< 1 hour
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28l. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Z. Eldadah MD Physician	D0054303	January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Z. A. ELDADAH, MD, Greater Baltimore Medical Center, 6701 North Charles Street, Baltimore, MD 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 22 2001	L. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02741

Physician /Medical Examiner

1. Decedent's Nama (First, Middle, Last): Edna B. Cox

2. Date of Death — Month: January Day: 14 Year: 2001

3. Time of Death: 15:10

4a Facility Nama (If not institution, give street and number): Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-28-8436

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 10, 1931

9. Birthplaca (Stata or Foraign Country): Maryland

Usual Rasidence of Decedent

10a. Stata: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 102 Kipling Court

10f. Zip Coda: 21009

10g. Citizan of What Country?: U. S. A.

11. Marital Status: 1☐Navar Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yas, Giva Yaar or Dates:

13. Was Dacedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada complatad) — Elementary/Secondary (0-12): 7th Grade — Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired): Assembly Worker

16b. Kind of Businass/Industry: Manufacturing

17. Fathar's Nama (First, Middla, Last): Grafton Stickles

18. Mothar's Neme (First, Middle, Maiden Surnama): Beulah Perry

19a. Informant's Name/Ralationship (Type, Print): Jackie L. Cox (Daughter)

19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code): 102 Kipling Court, Abingdon, Maryland 21009

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from Stata 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Name of cematary, cramatory or othar place): Green Mount Crematory

Data: 1/18/01

20c. Location - City or Town, Stata: Baltimore, Maryland

21. Signature of Funaral Sarvice Licensee: ▶ Brian A. Wellem

22. Name and Addrass of Facility: Schimunek Funeral Home of Bel Air Inc. 610 W. Macphail Rd., Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or heart teilure. List only ona ceusa on each line.

Approximate Intarvat Batween Onsat and Daath

Immediata Causa (Final disease or condition resulting in deeth)

a. Sepsis — 24hr

Due to (or as a consequance ot): Pneumonia

b. — 48hr

Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disease or injury that initiated events resulting in death) Last

Dua to (or as a consequanca ot):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part t.: End Stage Emphysema

23b. Did tobacco uas contributa to the causa of death? 1☐Yas 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? ☒Yas 2☐No

24b. Were autopsy findings available prior to completion of cause of deeth? 1☐Yas 2☒No

25. Was case referred to medical examiner? 1☐Yas 2☒No

26. Placa ot Deeth (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☐Rasidance 6☐Othar (Specify)

27. Manner of Deeth: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending investigation 6☐Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To tha best of my knowledge, daath occurred at the time, data and place, and due to the ceuse(s) and manner as stated. 2☐**Medical Examiner:** On tha basis of examinetion and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: ▶ [signature]

29c. Licansa number: D0053568

29d. Data signed (Month, Day, Year): January 14, 2001

30. Name and addrass of parson who completed cause of death (Item 23a) (Type, Print): Jeffrey A. Thomson MD

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

BF

Edna Cox

6

01-0375-037
jhm
JOHN TIMOTHY
CUSIC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEMS# 23a,ptII,27, & 28a-f per ME G792 021401 ss

Reg. No. 2001 02742

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Timothy Cusic, Sr.

2. Date of Death Month Day Year: JANUARY 22, 2001

3. Time of Death: 19:29 PM

4a. Facility Name (If not institution, give street and number): ST. MARYS HOSPITAL

4b. City, Town, or Location of Death: LEONARDTOWN

4c. County of Death: ST. MARYS

Funeral Director

5. Social Security Number: 219-73-8309

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 37 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 4,1963

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 25845 Friendship School Road

10f. Zip Code: 20659

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Giva Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Worker

16b. Kind of Business/Industry: Housing Construction

17. Father's Name (First, Middle, Last): John Philip Cusic

18. Mother's Name (First, Middle, Maiden Surneme): Mary Ada Higgs

19a. Informant's Name/Relationship (Type, Print): George Philip Cusic (Brother)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code): 28971 Hill and Dale Drive, Mechanicsville, Maryland 20659

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or othar place): Charles Memorial Gardens

Date: 1/26/01

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael K Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MIXED ETHANOL AND DRUG INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.: DEPRESSION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yaa 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Waa an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [X] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [X] Could not be determined

28a. Date of Injury (Month, Day Year): FOUND: 1-22-01

28b. Time of Injury: FOUND: 6:35 pM

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: unknown

28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify): found in dwelling

28f. Location (Street and Number or Rural Route Number, City or Town, State): 22441 Torino Drive Lexington Park, MD

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the causa(s) and manner as stated. 2 [X] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Dennis J Clute MD

29c. Licansa number: OCME

29d. Data signed (Month, Day, Year): JANUARY 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chutena 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 1 2001

32. Registrar's Signature: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02743

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NEVA KATHERINE CONRAD

2. Date of Death — Month: Jan; Day: 16; Year: 2001

3. Time of Death: 7:50 AM

4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 213-22-6059

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT 10 1913

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 610 DUTCHMANS LANE

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TELEPHONE OPERATOR

16b. Kind of Business/Industry: COMMUNICATIONS

17. Father's Name (First, Middle, Last): HOWARD B. STREETS

18. Mother's Name (First, Middle, Maiden Surname): CLARA E. SALISBURY

19a. Informant's Name/Relationship (Type, Print): BEATRICE E. CONRAD/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 216 S. AURORA ST. EASTON, MD 21601

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): SPRING HILL CEMETERY

Date: 1-22-01

20c. Location - City or Town, State: EASTON, MD 21601

21. Signature of Funeral Service Licensee: Joseph M. Ostrowski

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia, source unidentified

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Arterial embolism, left upper extremity

Atrial fibrillation, chronic

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Crowley MD

29c. License number: D25933

29d. Date signed (Month, Day, Year): 1.16.01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL CROWLEY, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Neva Conrad
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBB

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02744

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDERICK D. CHAPPELL JR.

2. Date of Death: Month JAN. Day 10, Year 2001

3. Time of Death: 11:58 AM

4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 423-32-1048

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 3, 1930

9. Birthplace (State or Foreign Country): ALABAMA

Usual Residence of Decedent

10a. State: D.C.

10b. County: NONE

10c. City, Town or Location: WASHINGTON

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2121 I ST. N.E. #4

10f. Zip Code: 20002

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTER

16b. Kind of Business/Industry: CARPENTRY

17. Father's Name (First, Middle, Last): JOHN CHAPPELL

18. Mother's Name (First, Middle, Maiden Surname): LOUEVONIA UNKNOWN

19a. Informant's Name/Relationship (Type, Print): MICHAEL CHAPPELL/GRANDSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3216 28th ST. S.E.#4, WASHINGTON, D.C. 20020

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MT. ZION CEMETERY

Date: 1/17/01

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: W. W. Chambers

MO0091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A. 5801 CLEVELAND AVE. RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung cancer — Due to (or as a consequence of): — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Head and neck Cancer.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) EMERGENCY ROOM

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D42403

29d. Date signed (Month, Day, Year): 1/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJ MATHUR 106 IRVING STREET NW WASHINGTON DC 20010

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02745

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrew Michael Church
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 5:55 pm
4a. Facility Name (If not institution, give street and number): Waterview Health Care Center
4b. City, Town, or Location of Death: Salisbury
4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-76-3224
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 14, 1953
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 105 Times Square
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None
16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Lloyd W. Church
18. Mother's Name (First, Middle, Maiden Surname): Ruby C. Bosma

19a. Informant's Name/Relationship (Type, Print): Christine M. Swerda - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11212 Odell Farms Court, Beltsville, MD 20705

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metropolitan Crematory
Date: 01/18/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ESOPHAGEAL RUPTURE → 3 WK
Due to (or as a consequence of):
b. PLEURAL EFFUSION/EMPYEMA → 3 WK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32014
29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAHESH MOONDRA 106 MILFORD ST SUITE B SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02746

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Isadora Minerva Carter
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 5:05AM

4a. Facility Name *(If not Institution, give street and number)*: Williamsport Nursing Home
4b. City, Town, or Location of Death: Williamsport
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 220-16-0581
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 26, 1909
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 17019 Burwood Court
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 5 | College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietary Technician
16b. Kind of Business/Industry: Hospital

17. Father'a Name *(First, Middle, Last)*: Millard Columbus Hanes
18. Mother's Name *(First, Middle, Maiden Surneme)*: Lillian May Boyer

19a. Informant's Neme/Relationship *(Type, Print)*: Virginia Persinger (Daughter)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 11105 Lakeside Drive Hagerstown, Maryland 21740

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, crematory or other piece)*: Smithsburg Crematory
Dete: Jan.19,2001
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Burtt E Osborne
22. Name and Address of Facility: Osborne Funeral Home 425 South Conococheague St. Williamsport, Maryland 21795

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Final disease or condition resulting in deeth)
a. ENDSTAGE PARKINSON'S DISEASE — YEARS

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the bast of my knowledge, deeth occurred et the time, dete and piece, and due to the cause(s) and mennar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ted Howe. MD
29c. License number: D33700
29d. Date signed *(Month, Day, Year)*: JANUARY 18, 2001

30. Name and addresa of person who completed cause of death (Item 23a) (Type, Print): TED HOWE 154 N. ARTIZAN ST. WILLIAMSPORT, MD 21795

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02747

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LESLEY O'NEAL COMBS

2. Date of Death (Month, Day, Year): January 22 2001

3. Time of Death: 19:19

4e. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hospital

4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 579-72-6290

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 4, 1952

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10e. State: MD

10b. County: Washington

10c. City, Town or Location: Williamsport

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 200 S. Artizan Street

10f. Zip Code: 21795

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: John W. O'Neal

18. Mother's Name *(First, Middle, Maiden Surname)*: Sonia Lesley

19e. Informant's Name/Relationship *(Type, Print)*: Sonia L. O'Neal/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7093 Catalpa Road, Frederick, Maryland 21703

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Greenlawn Memorial Park

Date: Jan.25

20c. Location - City or Town, State: Williamsport, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Douglas A. Fiery Funeral Home 21742, 1331 Eastern Blvd.,N.,Hagerstown, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PROBABLE ACUTE MYOCARDIAL INFARCTION — MINUTES

Due to (or as a consequence of):

b. CORONARY VASOSPASM — 3 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. PRINZMETAL ANGINA — 3YEARS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HISTORY OF NONSUSTAINED VENTRICULAR TACHYCARDIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] FOR BF

29c. License number: D38892

29d. Date signed *(Month, Day, Year)*: 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAMELA FOX BRADFORD MD 11110 MEDICAL CAMPUS RD. SUITE 130 HAGERSTOWN, MD 21742

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 2 4 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Combs, Lesley

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02748

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PETER CRINIGAN

2. Date of Death (Month, Day, Year): JANUARY 27, 2001

3. Time of Death: 1:00 AM

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 053-12-4193

8. Sex: X 1 M 2 F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 17, 1920

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: St. Leonard

10d. Inside City Limits: 1 Yes XX 2 No

10e. Street and Number: 4821 South Lane

10f. Zip Code: 20685

10g. Citizen of What Country?: United States

11. Marital Status: 1 Never Married 2 Married XX Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 No. If Yes, Give Year or Dates: 1941-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes 2 X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+): -

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Plumber

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Eugene Crinigan

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose McArdle

19a. Informant's Name/Relationship *(Type, Print)*: Peter T. Crinigan - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4821 South Lane St. Leonard, MD 20685

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veteran's Cem. Cheltenham

Date: Feb. 2, 2001

20c. Location - City or Town, State: Cheltenham Maryland

21. Signature of Funeral Service Licensee: [signature] MO1095

22. Name and Address of Facility: Rausch Funeral Home, p.a. 4405 Broomes Island Rd. Port Republic, MD 20676

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multisystem Organ Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cholangitis

Due to (or as a consequence of):

c. choledocholithiasis.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Esophageal Cancer

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes XX No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other *(Specify)*

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD.

29c. License number: D47906

29d. Date signed *(Month, Day, Year)*: 1/27/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GINA MASSOGLIA, MD 110 HOSPITAL RD. PRINCE FREDERICK, MD. 20678

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020 Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMND ITM#5 PR. F.H. G800 10-17-01 JAB

Certificate of Death

Reg. No. 2001 02749

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nellie Mann Carson

2. Date of Death — Month: January; Day: 15; Year: 2001

3. Time of Death: 23:36

4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-32-~~0934~~ 0924

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 20, 1906

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 218 - 14th St., N.E.

10f. Zip Code: 20002

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. African *Specify:* American

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 8th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maid

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Weldon McDowell

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Myrna Fawcett - Court Appointed Guardian

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1763 R St., N.W. Wash., D.C. 20009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glenwood Cemetery — Date: 1/24/2001

20c. Location - City or Town, State: Wash., D.C.

21. Signature of Funeral Service Licensee: John I. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction — 3 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
b. Coronary Artery Disease — Years

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James J. DelVecchio MD

29c. License number: D44521

29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): James A. Delvecchio, M.D. 1500 Forest Glen Rd., Silver Spring, MD 20910

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02750

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Nina Minkoff Cohen

2. Date of Death (Month, Day, Year): Jan. 12, 2001

3. Time of Death: 5:45P.

4a. Facility Name (If not institution, give street and number): Hebrew Home of Greater Washington

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 129-28-2310

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 14, 1934

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedant

10a. State: n/a

10b. County: n/a

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 3110 Rodman Street, N.W.

10f. Zip Code: 20008

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yas, specify Cuben, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; Collega (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Isaiah Cohen

18. Mother's Name (First, Middle, Maiden Surname): Dussia Sampson

19a. Intormant's Name/Relationship (Type, Print): Daniel Cohen - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 39 Wood Lane Rockville, Maryland 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other piece): King David Memorial Garden

Date: 1/15/2001

20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or comptications that caused the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech tine.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaase or condition resulting in death)

a. RESPIRATORY FAILURE — YEARS

Due to (or es a consequence ot):

b. BRONCHIECTASIS — YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: PULMONARY FIBROSIS

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place ot Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ptece, and due to the cause(s) and manner stated.

29b. Signature and title ot certifier: Steven Lipson MD

29c. License number: D 05885

29d. Data signed (Month, Day, Year): 01/12/01

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0289-047
jhm
LOUISE
DAILEY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02751

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LOUISE FREY DAILEY
2. Data of Death Month Day Year: JANUARY 17, 2001
3. Time of Death: 22:00 PM
4e. Facility Name *(If not institution, give street and number)*: ATLANTIC GENERAL HOSPITAL
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 390-12-3114
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 7/25/1918
9. Birthplace *(State or Foreign Country)*: WI

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10439 Assateague RD
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Evar in U.S. Armed Forces?: 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) | College (1-4or 5+): 5
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Co-Owner/ Operator
16b. Kind of Business/Industry: General Store

17. Father's Neme *(First, Middle, Last)*: Warren H. Frey
18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Bertha E. (Unknown)

19e. Informent's Neme/Reletionship *(Type, Print)*: Bruce W. Dailey/ Son
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 10439 Assateague RD Berlin, MD 21811

20e. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☒ Other *(Specify)* Entombment
20b. Plece of Disposition *(Neme of cemetery, cremetory or other piece)*: Evergreen Cemetery
Dete: 1/21/01
20c. Location - City or Town, State: Berlin, MD

21. Signeture of Funeral Service Licensee: W. Fisk Burbage
22. Neme end Addrass of Fecility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Intervel Between Onsat end Death

Immediate Causa (Final disease or condition resulting in deeth)
a. Multiple injuries
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Plece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*

27. Menner of Death: 1☐ Neturel 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*: 1/17/01
28b. Time of Injury: 2142 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Subject driving vehicle involved in vehicle accident
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: roadway
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*: Route 346 + Route 113 Berlin Maryland

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Theodore M. King MD
29c. License number: OCME
29d. Date signed *(Month, Day, Year)*: JANUARY 18, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): THEODORE McKING, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: Geneva G. Sparks

10

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02752

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul L. Dickerson

2. Date of Death: Month: JANUARY Day: 18 Year: 2001

3. Time of Death: 0104

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 202-18-8971

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11/14/1924

9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Delaware

10b. County: Sussex

10c. City, Town or Location: Delmar

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: Rt 2 Box 29

10f. Zip Code: 19940

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired):

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): Edward James Dickerson

18. Mother's Name (First, Middle, Maiden Surname): Amanda Givens

19a. Informant's Name/Relationship (Type, Print): Neil Baker Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 2 Box 269A, Delmar, DE 19940

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. Stephens Cemetery | Date: 1/21/2001

20c. Location - City or Town, State: Delmar, Delaware

21. Signature of Funeral Service Licensee: William M. Short

22. Name and Address of Facility: Short Funeral Home 13 E. Grove St Delmar, DE 19940

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Community Acquired Pneumonia — 10 days

Due to (or as a consequence of):
b. Sepsis — 10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Severe Rheumatoid Arthritis

Anemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L Brandon, D.O

29c. License number: H005783

29d. Date signed (Month, Day, Year): 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L Brandon, D.O. 1201 Pemberton Dr. Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Penne A. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

PAUL DICKERSON SS 202-18-8971 1.18.01 0104 76yo

20 mg IVA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02753

DOUGHTY, JOHN ED

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Edgar Doughty
2. Date of Death: Month JANUARY, Day 17, Year 2001
3. Time of Death: 2:45 A.M.
4a. Facility Name (If not institution, give street and number): Berlin Nursing Home
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 216-05-8638
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Yaar: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 8/27/1911
9. Birthplaca (State or Foreign Country): Virginia

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Wicomico
10c. City, Town or Location: Delmar
10d. Inside City Limits: 1 [ ] Yas 2 [X] No
10e. Streef and Number: 8428 Rum Ridge Road
10f. Zip Code: 21875
10g. Citizen of What Countfy?: USA

11. Marital Stafus: 1 [ ] Nevar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No. If Yes, Give Yaer or Datas: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementery/Secondery (0-12); College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tax assessor
16b. Kind of Business/Industry: County Tax Office

17. Fathar's Neme (First, Middle, Last): Rosser C. Doughty
18. Mother's Neme (First, Middle, Meiden Surname): Edith Steffee

19a. Informent's Neme/Relationship (Type, Print): Marie Doughty Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8428 Rum Ridge Road, Delmar, MD 21875

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Ptece of Disposition (Name of cemetery, crematory or othar place): Makemie Presbyterian Cemetery
Date: 1/19/2001
20c. Location - City or Town, Steta: Snow Hill, Maryland

21. Signature of Funeral Service Licensee: ▶ William M. Short
22. Name end Address of Facility: Short Funeral Home, 13 E. Grove Street, Delmar, DE 19940

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enfer tha disease, or comptications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart faiture. List only one ceuse on each tine.

Approximete tnterval Between Onset and Deeth

Immediete Ceuse (Finat disease or condition resulting in death)
a. Alzheimer Disease — 7 years
Due to (or as e consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentiatly list conditions, if any, leading to immediete ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditione** contributing fo death but not resulting in the undarlying causa givan in Part I.
By Pen Coumary -
Diffuse Arteriosclerosi

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No
26. Ptace of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of tnjury (Month, Day Year)
28b. Time of Injury M
28c. tnjury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, and due to the causa(s) end menner es stated. 2 [ ] **Medicat Examiner**: On the basis of examination and/or investigation, In my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner steted.

29b. Signatura and title of certifier: ▶
29c. License number: D02026
29d. Data signed (Month, Day, Year): 1-17-01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: ▶ D. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3 MP
1 VA

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29d per Phy. 01/18/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2001 02754
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Depew
2. Date of Death Month/Day/Year: 01/16/2001
3. Time of Death: 4:00 P.M
4a. Facility Name (If not institution, give street and number): Westminster Nursing & Convalescent Ctr
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 198-22-8921
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 27, 1928
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9 Park View Terrace
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5 +
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assoc. Dean of Students
16b. Kind of Business/Industry: West Chester State University

17. Father's Name (First, Middle, Last): James DePew
18. Mother's Name (First, Middle, Maiden Surname): Katherine (Unknown)

19a. Informant's Name/Relationship (Type, Print): Carol Fritz (Friend)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 Park View Terr. Westminster, MD 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chestnut Hill Cem
Date: 1-19 2001
20c. Location - City or Town, State: Mechanicsburg, PA

21. Signature of Funeral Service Licensee: Jean K. Ault
22. Name and Address of Facility: Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Renal Failure
Due to (or as a consequence of):
b. Dehydration
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Multi infarct dementia
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James L. Forsberg, MD
29c. License number: D33561
29d. Date signed (Month, Day, Year): Jan. 17, 2001 ~~01/17/2000~~

30. Name and address of person who completed cause of death (Item 29a) (Type, Print): James L. Forsberg, MD 1380 Progress Way Suite 114, Eldersburg, MD 21784

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02755

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph THEODORE Dines, SR
2. Date of Death: Month JANUARY Day 9 Year 2001
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): Doctors Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-10-2360
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 19, 1912
9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8511 Bonny Drive
10f. Zip Code: 20747
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Management
16b. Kind of Business/Industry: Howard University Private

17. Father's Name (First, Middle, Last): Ralph L. Dines
18. Mother's Name (First, Middle, Maiden Surname): Mary E. Brown

19a. Informant's Name/Relationship (Type, Print): Dorothy B. Dines - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8511 Bonny Dr., Forestville, MD 20747

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Park Maryland National Mem.
Date: 1/20/2001
20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CONGESTIVE HEART FAILURE
Due to (or as a consequence of):
b. AORTIC VALVE DISEASE
Due to (or as a consequence of):
c. ENDOCARDITIS
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
EXTENSIVE BONE METASTASIS
ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: 042249
29d. Date signed (Month, Day, Year): 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAYMOND NWANJUKO 9831 GREENBELT RD STE 101 LANHAM MD 20706

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: G. Apacks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02756

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Calvin Herbert Dean

2. Date of Death (Month, Day, Year): January 7, 2001

3. Time of Death: 4:00 p.m.

4a. Facility Name (If not institution, give street and number): 26900 Three Notch Road

4b. City, Town, or Location of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 218-14-3211

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 27, 1922

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 26900 Three Notch Road

10f. Zip Code: 20659

10g. Citizen of Whet Country?: U S A

11. Meritel Stetus: 1☐Never Merried 2☒Merried 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Scheduler

16b. Kind of Business/Industry: U.S. Government

17. Father's Neme (First, Middle, Last): Luther Franklin Dean, Sr.

18. Mother's Neme (First, Middle, Maiden Surname): Lillian Grace Jones

19a. Informent's Neme/Reletionship (Type, Print): Dorothy V. Dean (Spouse)

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 20659: 26900 Three Notch Road, Mechanicsville, Maryland

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mt. Zion MethodistCemetery

Dete: 1/12/01

20c. Location - City or Town, Stete: Mechanicsville, Maryland

21. Signeture of Funerel Service Licensee: Joseph Bates Cyst

22. Neme end Address of Facility: Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatitis — Approx. Interval: 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease
Central Vascular Disease
Hypertrophic Cardiomyopathy
Bladder Cancer

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and menner as stated. 2☐Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: David M Federle

29c. License number: D34198

29d. Date signed (Month, Day, Year): 1/9/01

30. Nama and address of person who completed ceuse of deeth (Item 23a) (Type, Print): David M. Federle, MD — Hollywood, Maryland 20636

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 10 2001

32. Registrar's Signeture: Donna B. Smith

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02757

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET ELIZABETH DICKSON
2. Date of Death: Month: JAn Day: 20 Year: 01
3. Time of Death: 10 Am
4a. Facility Name (If not institution, give street and number): 1314 Potomac Ave., Apt. 26
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 150-03-7492
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 87 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 27, 1913
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1314 Potomac Ave., Apt. 26
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Milk Company

17. Father's Name (First, Middle, Last): John Dickson
18. Mother's Name (First, Middle, Maiden Surname): Margaret Bennett

19a. Informant's Name/Relationship (Type, Print): Dorothy Mae Dixon/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19826 Marvin Avenue, Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hillside Cemetery
Date: Jan.29
20c. Location - City or Town, State: Plainfield, NJ

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary occlusion — sudden
Due to (or as a consequence of):
b. Atherosclerotic disease — years

Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D0011266
29d. Date signed (Month, Day, Year): January 23, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Howard N. Weeks, MD 580 Northern Ave. Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 2 3 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02758

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AGOSTINO DiCAMILLO
2. Date of Death (Month, Day, Year): JANUARY 13 2001
3. Time of Death: 1:21 PM
4a. Facility Name (If not institution, give street and number): Villa Rosa Nursing Home
4b. City, Town, or Location of Death: Mitchelleville
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-01-2875
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 97 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 18, 1903
9. Birthplace (State or Foreign Country): Argentina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 620 Sheridan St., Apt. 115
10f. Zip Code: 20782
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tile Setter's Helper
16b. Kind of Business/Industry: Tile Company

17. Father's Name (First, Middle, Last): Nicola DiCamillo
18. Mother's Name (First, Middle, Maiden Surname): Ernestina Sidoni

19a. Informant's Name/Relationship (Type, Print): Maria Carmela DiCamillo / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 Marshall Manor, Silver Spring, Maryland 20905

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: 01/17/01
20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: James J. Schmaltz
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — week

Due to (or as a consequence of):
b. Parkinsonism — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D12261
29d. Date signed (Month, Day, Year): 1-15-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] J. Feldman MD 9500 Arandale Rd, Landover MD 20706

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02759

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael David Evans

2. Date of Death (Month, Day, Year): January 10, 2001

3. Time of Death: 2210

4a. Facility Name (If not institution, give street and number): Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-57-8937

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 23, 1946

9. Birthplace (State or Foreign Country): OH

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 19343 Hottinger Circle

10f. Zip Code: 20874

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Heating & Air Conditioning

17. Father's Name (First, Middle, Last): Richard Edward Evans

18. Mother's Name (First, Middle, Maiden Surname): Marriane Williams

19a. Informent's Name/Relationship (Type, Print): Judith Larmer /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19343 Hottinger Circle, Germantown, MD 20874

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: Jan 15 2001

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: ▶ Beverly L. Hewitt

22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic lung cancer — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] S07[illegible]

29c. License number: D43083

29d. Date signed (Month, Day, Year): January 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE A. SOTOS, MD 9707 Medical Center Drive #300 Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02760

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): AGNES M. ETTZ

2. Date of Death Month Dey Year: JANUARY 17 2001

3. Time of Death: 01:20

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

5. Social Security Number: 140-34-1253

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 5/10/1943

9. Birthplace (State or Foreign Country): NJ

Usual Residence of Decedent

10a. State: DE

10b. County: Sussex

10c. City, Town or Location: Frankford

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: RT 2 Box 135-5

10f. Zip Code: 19945

10g. Citizen of What Country: USA

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondery (0-12):
College (1-4or 5+): 2

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Retail

17. Father's Neme (First, Middle, Last): Henry Krowska

18. Mother's Name (First, Middle, Maiden Sumame): Agnes Lopusnak

19e. Informent's Name/Relationship (Type, Print): Thomas M. Ettz/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT 2 Box 135-5 Frankford, DE 19945

20e. Method of Disposition: ☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Evergreen Cemetery

Date: 1/20/01

20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: W. Bria Burbage

22. Name and Address of Fecility: Burbage Funeral Home
108 William St. Berlin, MD 21811

Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Finel diseese or condition resulting in deeth)
a. ACUTE LEUKEMIA — 1 YEAR
Due to (or es a consequence of):

Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one)
Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, tectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: RESIDENT

29c. License number: RES-000

29d. Date signed (Month, Day, Year): JANUARY 17, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)
SHAIN LATIF TOWER 110 DOCTOR'S LOUNGE JOHNS HOPKINS HOSPITAL 600 N. WOLFE ST BALTIMORE MD 21287

2

State Registrar

31. Date filed (Month, Dey, Year): JAN 19 2001

32. Registrar's Signature: Bruce G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02761

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Linda Lou Erskine

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 10:10 AM

4a. Facility Name *(If not Institution, give street and number)*: 38392 John Wayne Court

4b. City, Town, or Location of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-58-8219

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 56 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 5, 1944

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 38392 John Wayne Court

10f. Zip Code: 20659

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 9th | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Deli Worker

16b. Kind of Business/Industry: Retail Food Store

17. Father's Name *(First, Middle, Last)*: Bedie Anderson

18. Mother's Name *(First, Middle, Maiden Surname)*: Frances Jane Markward

19a. Informent's Name/Relationship *(Type, Print)*: George H. Erskine, Jr. (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 38392 John Wayne Court, Mechanicsville, Maryland 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charles Memorial Gardens

Date: 1/22/01

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael Kevin Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinomatosis — months

Due to (or as a consequence of):
Ovarian Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of): — yrs
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4■ Unknown

24a. Was an autopsy performed? 1☐ Yes 2■ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2■ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5■ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1■ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1■ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Patrick Jarboe M.D.

29c. License number: D 06419

29d. Date signed *(Month, Day, Year)*: 1-19-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Patrick Jarboe, MD Hollywood, Maryland 20636

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

5 Copies

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02762

Alice Eveland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Alice Marie Eveland	Jan. 18, 2001	1905

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Memorial Hospital	Easton	Talbot

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-62-1504	1☐ M 2☒ F	88 Yrs.			February 13, 1912	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Caroline	Ridgely	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
11771 Ridgely Road	21660	United States

11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No *Specify:*	*Specify:* Caucasian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11 HS Grad.		Homemaker	Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Raymond Cleveland Wood	Elizabeth Lawless

19a. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William P. Eveland Son	11713 Ridgely Road, Ridgely, Maryland 21660

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)	Holy Cross Cemetery	1/23/01	near Greensboro, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Randolph P Moore	Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Myocardial Infarction	7 day
Due to (or as e consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Congestive heart failure	7 day
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease
Bronchiectasis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end menner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	039749	1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Greg Oliver, M.D., 503 Dutchmen's Lane, Easton, Maryland 21601

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 22 2001	B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02763

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GENEVIEVE P. EMMELL
2. Date of Death (Month, Day, Year): JAN. 13, 2001
3. Time of Death: 7:35 AM
4a. Facility Name (If not institution, give street and number): FOREST GLEN NURSING HOME
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 053 22 9991
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Fe. 23, 1929
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince Georges
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4124 CROSSWICK TURN
10f. Zip Code: 20715
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): FRANK SHIELDS
18. Mother's Name (First, Middle, Maiden Surname): GENEVIEVE KIRWAN

19a. Informant's Name/Relationship (Type, Print): KATHLEEN GENTHNER/DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8415 SPRUILL DR., BOWIE, MD. 20720

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN CEM. Date: JAN. 17, 2001
20c. Location - City or Town, State: SILVER SPRING, MD. 20905

21. Signature of Funeral Service Licensee: Michael D. Ogle
22. Name and Address of Facility: ROBERT E. EVANS FUNERAL HOME, 16000 ANNAPOLIS RD., BOWIE, MD. 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
a. Bacteremia — Approximate Interval Between Onset and Death: 1 month
Due to (or as a consequence of):
b. dehydration
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [illegible] MD
29c. License number: D53528
29d. Date signed (Month, Day, Year): January 15, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sophia Gerding, MD, 2309 SHOREFIELD RD., WHEATON, MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02764

NAME: HAROLD J. EILER

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Harold J. Eiler

2. Dete of Deeth — Month: JANUARY; Dey: 10; Yeer: 2001

3. Time of Death: 02:34 P.M.

4a Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Deeth: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 075-14-4445

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: August 17, 1920

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 4216 Carriage Drive

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No
If Yes, Give Yeer or Dates: War Viet Nam

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.)
1 [ ] Yes 2 [X] No Specify:

14. Rece - Americen Indien, Bleck, White, etc.
Specify: White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired E6

16b. Kind of Business/Industry: U.S. Navy

17. Fether's Neme *(First, Middle, Last)*: Frank Eiler

18. Mother's Neme *(First, Middle, Maiden Surname)*: Carrie Gelhaus

19a. Informent's Name/Reletionship *(Type, Print)*: Doris M. Eiler (WIFE)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 4216 Carriage Drive , Temple Hills, MD 20748

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Maryland Veterans Cemetery — Jan 18, 2001

20c. Location - City or Town, Stete: Cheltenham, Maryland

21. Signeture of Funeral Service Licensee: [signature]

22. Neme end Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton , Maryland 20735

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert leilure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel disease or condition resulting in death): e. MYOCARDIAL INFARCTION — 02 HOURS

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*
Hospital: 1 [ ] Inpetient 2 [X] ER/Outpetient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and manner as steted.
2 [ ] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and menner stated.

29b. Signeture end title of certifier: [signature]

29c. License number: MD D52533

29d. Dete signed *(Month, Dey, Yeer)*: JANUARY 10, 2001

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): ANGELA G. FOWLER-BROWN, CAPT, USAF, MD — 89 MDG/1050 W. PERIMETER RD. ANDREWS AIR FORCE BASE, MD 20762-6600

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 17 2001

32. Registrer's Signeture: [signature] G. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02765

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Daniel Joseph Fitzgerald, Jr.

2. Date of Death Month Day Year: January 14, 2001

3. Time of Death: 10:00 am

4a. Facility Name *(If not institution, give street and number)*: 6925 Heidelburg Road

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 013-20-0035

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec 22, 1927

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 6925 Heidelburg Road

10f. Zip Code: 20706

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1946-1966

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Technician

16b. Kind of Business/Industry: C & P

17. Father's Name *(First, Middle, Last)*: Daniel Joseph Fitzgerald, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Julie Powell

19a. Informant's Name/Relationship *(Type, Print)*: Susan J. Fitzgerald / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6925 Heidelburg Road , Lanham, MD 20706-4602

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland National Memorial Park

Date: Jan 17 2001

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: James S Dooley

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. Date of Injury *(Month, Day, Year)*

26b. Time of Injury M

26c. Injury at Work? 1 [ ] Yes 2 [ ] No

26d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D. Singh MD

29c. License number: D45660

29d. Date signed *(Month, Day, Year)*: 1-15-2001

30. Name and address of person who completed cause of death (item 23a) (Type, Print): D. Singh, MD 14300 Gallant Fox Lane Suite124, Bowie, MD 20715

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02766

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Fischer
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 5:00 A.M.
4a. Facility Name (If not institution, give street and number): 45623 Legerton Lane
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 059-10-9320
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 19, 1907
9. Birthplace (State or Foreign Country): Germany

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1☐Yas 2☒No
10e. Street and Number: 45623 Legerton Lane
10f. Zip Code: 20653
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Valentin Heeb
18. Mother's Name (First, Middle, Maiden Surname): Barbara Wahlig

19a. Informant's Name/Relationship (Type, Print): Margaret DiPreta (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45623 Legerton Lane, Lexington Park, Maryland 20653

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Holy Rood Cemetery
Date: 1/18/2001
20c. Location - City or Town, State: Westbury, New York

21. Signature of Funeral Service Licensee: Mary B. Rizzo 101114
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Cancer of The Colon — YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred: —
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State): —

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. Licensa number: 014285
29d. Date signed (Month, Day, Year): 1-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyd, II, MD Leonardtown, Maryland 20650

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02767

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Janet Ruth Funk

2. Date of Death (Month, Day, Year): January 3, 2001

3. Time of Death: 1:47 p.m.

4a. Facility Name (If not institution, give street and number): Bayside Care Center

4b. City, Town, or Location of Death: Lexington Park

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 224-16-9296

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): February 13, 1921

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: California

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 23756 St. Clair Lane

10f. Zip Code: 20619

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Food Service

16b. Kind of Business/Industry: hospital

17. Father's Name (First, Middle, Last): Claude Eckard

18. Mother's Name (First, Middle, Maiden Surname): Linnie May Simmons

19a. Informant's Name/Relationship (Type, Print): Donald Lee Byers Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23756 St. Clair Lane, California, Maryland 20619

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Panorama Memorial Garden

Date: January 7, 2001

20c. Location - City or Town, State: Front Royal, Virginia

21. Signature of Funeral Service Licensee: Mary Rizzo M01114

22. Name and Address of Facility: Brinsfield Funeral Home, P.A., 22955 Hollywood Road, P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Sepsis — Two days.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

① Cerebrovascular Accident

② Decubitus ulcer.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: SC Gabr M.D.

29c. License number: D54346

29d. Date signed (Month, Day, Year): 1/5/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chandra B. Sajja, Hollywood, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02768

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Iris FREEMAN
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 3:30 a.m.
4a. Facility Name *(If not institution, give street and number)*: Avalon Manor
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 230-20-8888
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 18, 1926
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1382 Outer Drive
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0-12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: her own home

17. Father's Name *(First, Middle, Last)*: Boyd Hartman
18. Mother's Name *(First, Middle, Maiden Surname)*: Cleda Keister

19a. Informant's Name/Relationship *(Type, Print)*: Holly J. Lemons - daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11 West Baltimore Street, Hagerstown, Maryland

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Comfort Cemetery
Date: Jan. 23, 2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Fred L Wentz
22. Name and Address of Facility: Minnich Funeral Home 415 East Wilson Blvd, Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiomyopathy — 2m

Due to (or as a consequence of):
b. Progressive Muscular Dystrophy — 2m

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Datta MD
29c. License number: D18019
29d. Date signed *(Month, Day, Year)*: Jan 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Vasant Datta 334 Mill Street Hagerstown, Md 21740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02769

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNA ELIZABETH FIALA
2. Date of Death Month Dey Yeer: JAN. 18, 2001
3. Time of Death: 9:35 PM
4a. Facility Name *(If not institution, give street and number)*: BEVERLY HEALTH CARE
4b. City, Town, or Location of Death: HAGERSTOWN
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 105-24-0148
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Yeer)*: 10/23/1914
9. Birthplece *(Stete or Foreign Country)*: CZECHOSLOVAKIA

Usuel Residence of Decedent

10a. Stete: WV
10b. County: BERKELEY
10c. City, Town or Location: MARTINSBURG
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 510 S. GEORGIA AVE.
10f. Zip Code: 25401
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Reca - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: CANCER RESEARCH
16b. Kind of Business/Industry: V A MEDICAL CENTER

17. Fether's Neme *(First, Middle, Last)*: ANTOS FROLKA
18. Mother's Neme *(First, Middle, Meiden Surneme)*: MARIA FALESNIKOVA

19a. Informent's Neme/Reletionship *(Type, Print)*: EMERICH FIALA/SON
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 2 SOUTHVIEW RD., CHAPPAQUA, NY 10514

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Plece of Disposition *(Neme of cemetery, cremetory or other plece)*: SMITHSBURG CREMATORY
Dete: 1/20/01
20c. Location - City or Town, State: SMITHSBURG, MARYLAND

21. Signeture of Funerel Servica Licensee: Charles M. Brown
22. Neme end Address of Fecility: BROWN FUNERAL HOME, 327 W. KING ST., PO BOX 821, MARTINSBURG, WV 25402

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE — MINS

Due to (or es e consequenca of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest
b.

Due to (or es e consequenca of):
c.

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29b. Signeture end titie of certifier: Manzar Shah
29c. License number: D 28365
29d. Date signed *(Month, Dey, Yeer)*: 1- 19- 01

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MANZAR SHAH 368 MILL ST. Hagerstown MD 21740

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 24 2001
32. Registrar Signature:

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the deeth certificete be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02770

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Beverly Ferramosca

2. Date of Death Month Day Year: January 14, 2001

3. Time of Death: 3:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: 2032 Henderson Avenue

4b. City, Town, or Location of Death: Wheaton

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-44-9182

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 26, 1933

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Wheaton

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2032 Henderson Avenue

10f. Zip Code: 20902

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner

16b. Kind of Business/Industry: Flower Shop

17. Father's Name *(First, Middle, Last)*: David McIntyre

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Ann Bovello

19a. Informant's Name/Relationship *(Type, Print)*: Vincent Ferramosca, Jr. - Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2032 Henderson Avenue, Wheaton, Maryland 20902

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery

Date: 1-18-01

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Vincent F. Hines

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 7 months

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John W. Boccia

29c. License number: D29675

29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ralph Boccia, M.D. 9707 Medical Center Drive, Rockville, Maryland 20853

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02771

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Spencer Freeman
2. Date of Death: Month January Day 16 Year 2001
3. Time of Death: 9:55 A.M.
4a. Facility Name (If not institution, give street and number): Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 136 14 4380
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 11, 1920
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 586 Pinewood Drive
10f. Zip Code: 21401
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Electronics

17. Father's Name (First, Middle, Last): Ralph Joseph Freeman
18. Mother's Name (First, Middle, Maiden Surname): Anna Hall

19a. Interment's Name/Relationship (Type, Print): Walt Freeman Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 586 Pinewood Dr. Annapolis Maryland 21401

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Maryland Veterans Cemetery Date: Jan. 23, 2001
20c. Location - City or Town, State: Cheltenham Maryland

21. Signature of Funeral Service Licensee: Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	1 week
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D. Th
29c. License number: D38958
29d. Date signed (Month, Day, Year): 1/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DaGeet Singh Sodhi 1413 Annapolis Road #106 odenton MD 21113

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: Bernard G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02772

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Henry Goff
2. Data of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 5:10 AM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-50-2141
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-6-1938
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9005 Goldfield Place
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Transportation Specialist
16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Augustus Goff
18. Mother's Name (First, Middle, Maiden Surname): Virgie Black

19a. Informant's Name/Relationship (Type, Print): Doris A. Goff/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9005 Goldfield Pl. Clinton, MD 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resurrection Cemetery
Date: 1-20-01
20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee ▶
22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. End stage Renal disease
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Sepsis
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of certifier ▶ A. Rahimian MD
29c. License number: D05299
29d. Date signed (Month, Day, Year): 01/14/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ALI RAHIMIAN MD 1328 Southern Ave # 200 Washington DC 20032

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02773

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cecelia Geiger
2. Date of Death (Month, Day, Year): January 14, 2001
3. Time of Death: 9:40 pm
4a. Facility Name (If not institution, give street and number): 9515 St. Andrews Way
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 145-58-8071
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 12, 1911
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9515 St. Andrews Way
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yea or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 1
16a. Decedent's Uaual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Buainass/Industry: Own Home

17. Father's Name (First, Middle, Last): James Lynch
18. Mother's Name (First, Middle, Maiden Surname): Ann Hoare

19a. Informant's Name/Ralationship (Type, Pnint): Ann G. Hunter / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9515 St. Andrews Way, Silver Spring, MD 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Madonna Cemetery
Date: Jan 20 2001
20c. Location - City or Town, Stata: Ft. Lee, NJ

21. Signature of Funeral Service Licansee: John E. Barber
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only ona cause on each line. (Approximate Intarval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Ischemic Cardiomyopathy — years

Due to (or as a consequenca of):
b. Coronary Atherosclerosis — years

Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or injury that initiated evants resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or es e consequence of):
d.

Part tI. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Daath (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA — Othar: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datermined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, straet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at the time, date and placa, and due to tha causa(s) and mannar as atated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, date and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Ronald Gross, M.D.
29c. License number: D 05568
29d. Data signed (Month, Day, Year): January 15, 2001

30. Name and addrass of person who completad cause of death (Item 23a) (Type, Print): Frank N. Gravino, MD 10313 Georgia Ave., Suite 307, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: pennway G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To be completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02774

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marguerete R. Graves
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 1108am
4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 542-32-3277
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 12, 1923
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2921 N. Liesure World Blvd. #118
10f. Zip Code: 20906
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Datas:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: James Reap
18. Mother's Name *(First, Middle, Maiden Surname)*: Cecilia Duffy

19a. Informant's Neme/Relationship *(Type, Print)*: Jeanne Hobbs /Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3044 Schubert Dr., Silver Spring, MD 20904

20a. Method of Disposition: ☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National
Date: Jan 19 2001
20c. Location - City or Town, State: Arlington, VA

21. Signeture of Funeral Service Licensee: Beverly L. Haith
22. Name end Addrass of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on eech line. — Approximate Intarval Batween Onsat end Death

Immediate Ceuse (Finel disease or condition rasulting in death)
a. Sepsis — 10 days

Dua to (or as a consequence of):
b. Acute renal failure — 10 days

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last

Due to (or as a consequenca of):
c. Ischemic Colitis — 3 months

Due lo (or as a consequenca of):
d. Atherosclerotic cardiovascular disease — 20 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.: History of hemorrhagic stroke

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably ☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medicel examiner? 1☐ Yes ☒ No
26. Placa of Death *(Check only one)*: Hospitel: ☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Deeth: ☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29b. Signatura and title of certifiar: Paul M
29c. License number: D43237
29d. Date signed *(Month, Day, Year)*: JANUARY 11, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Armstrong M.D. 14201 Laurel Park Dr., Laurel, MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0284-510

JEANNE GRIFFITH

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02775

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEANNE LEINBACH GRIFFITH

2. Date of Death Month Day Year: JANUARY 17, 2001

3. Time of Death: 7:41P.M.

4a. Facility Name (If not institution, give street and number): SHOCK TRAUMA CENTER

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: - -

Funeral Director

5. Social Security Number: 213-12-2546

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/13/1921

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2719 Register Farm Road

10f. Zip Code: 21050

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive Secretary

16b. Kind of Business/Industry: Consultant

17. Father's Name (First, Middle, Last): Charles Leinbach

18. Mother's Name (First, Middle, Maiden Surname): Louisa Krug

19a. Informent's Name/Reletionship (Type, Print): Dwight Griffith /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10 a,b,c,e,f

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation

Date: 1/19 2001

20c. Location - City or Town, Stete: Hampstead, Maryland

21. Signeture of Funaral Service Licensee: M. Blackburn Kurtz III

22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part1. Entar the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Multiple Injuries

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that intieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other signifficant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yaa 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 1-16-01

28b. Time of Injury: 1823p M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: motor vehicle collision

28e. Plece of injury - At home, farm, street, fectory, offica building, etc. (Specify): street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Belair Road Gremacy Park, Md

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and pleca, end due to the cause(s) and mannar as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier: Dennis J Chutem

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 18, 2001

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print): Dennis J Chutem 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02776

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen Ella Gerberti

2. Date of Death — Month: 1 Day: 17 Year: 01

3. Time of Death: 4:30 am

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 166-05-0420

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 90 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 5, 1910

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1503 Scarlet Oak Ct.

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Andrew (u/k) Seroka

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie (u/k) Belanik

19a. Informant's Name/Relationship *(Type, Print)*: Suzanne A. Welsh / Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1503 Scarlet Oak Ct., Bel Air, MD 21014

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens

Date: 1-20-01

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Rusch

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, Maryland 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Helen Gerberti

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multifarct Dementia — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHF, ASCVD, Atrial fibrillation,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Bl.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Raymundo

29c. License number: D54518

29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 3007 E Northern Parkway Baltimore MD 21214

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02777

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virgil Ray Goff

2. Date of Death (Month, Day, Year): Jan 18, 2001

3. Time of Death: 0555

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 293-28-9561

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 68 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 23, 1932

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Finksburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2217 Ridgemont Drive

10f. Zip Code: 21048

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Manager

16b. Kind of Business/Industry: Oil Company

17. Father's Name (First, Middle, Last): Albert Goff

18. Mother's Name (First, Middle, Maiden Surname): Alberta Mooney

19a. Informant's Name/Relationship (Type, Print): Barbara Goff, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2217 Ridgemont Dr, Finksburg, MD 21048

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremations

Date: 1/20/2001

20c. Location - City or Town, State: Hampstead, MD

21. Signature of Funeral Service Licensee: Steven W Eline MD0723

22. Name and Address of Facility: Eline Funeral Home, 934 South Main St, Hampstead, MD 21074

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. SUDDEN CARDIAC DEATH

Due to (or as a consequence of):
b. ISCHEMIC CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CHF

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: H0039447

29d. Date signed (Month, Day, Year): 01/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SCOTT JEROME 1130 Baltimore Blvd. Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02778

James Gannon
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES LEO GANNON, JR.
2. Date of Death (Month, Day, Year): Jan. 13, 2001
3. Time of Death: 1019
4a. Facility Name (If not institution, give street and number): The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 213-14-1210
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 22, 1922
9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 29465 HAWKES HILL ROAD
10f. Zip Code: 21601
10g. Citizen of What Country?: USA
11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT
16b. Kind of Business/Industry: CAR SALES
17. Father's Name (First, Middle, Last): JAMES LEO GANNON, SR
18. Mother's Name (First, Middle, Maiden Surname): ETHEL RHODES
19a. Informant's Name/Relationship (Type, Print): MARIA G. NIMMO/ DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11401 CHAPEL ROAD, CORDOVA, MD 21625
20a. Method of Disposition: 1 [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN MEMORIAL PARK
Date: 1-17-2001
20c. Location - City or Town, State: EASTON, MD
21. Signature of Funeral Service Licensee: M. E. Newnam III C.F.S.P.
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sudden Death- Myocardial Infarction — 1°

Due to (or as a consequence of):
b. Hypertension — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypothyroidism, Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jeffrey J. Denton MD
29c. License number: D47492
29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY J. DENTON, M.D., 555 CEDARWOOD DRIVE, EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02779

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Mary Elizabeth Gillispie
2. Deta of Death — Month: Jan; Dey: 20; Year: 2001
3. Time of Death: 0045
4e. Facility Neme (If not institution, give street and number): Clearview Nursing Home
4b. City, Town, or Location of Death: Hagerstown
4c. County of Deeth: Washington

Funeral Director

5. Social Security Number: 214-42-3619
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 4-18-1943
9. Birthplece (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stata: Md.
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 127 E. Washington St.
10f. Zip Code: 21740
10g. Citizen of Whet Country?: U.S.A
11. Maritel Status: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yas, Giva Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home
17. Father's Neme (First, Middle, Last): Arthur P.G. Goode
18. Mother's Name (First, Middle, Maiden Surname): Hazel Rison
19a. Informant's Name/Relationship (Type, Print): Casie L. Gillispie (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 2325 Hagerstown, Md. 21740
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory — Date: Jan. 22, 2001
20c. Location - City or Town, State: Smithsburg, Md.
21. Signature of Funeral Service Licensee: Dennis L Davis
22. Name and Address of Facility: Davis Funeral Home — 12525 Bradbury Ave. Smithsburg, Md. 21783

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death):
a. acute bronchopneumonia — 48 hours
Due to (or as a consequence of):
b. carcinoma lung
Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
metastasis to neck
post surgery for tracheotomy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and menner steted.

29b. Signatura and titla of certifier: Edson B. Moody
29c. License number: D07857
29d. Date signed (Month, Dey, Year): 1-22-01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Edson B. Moody M.D. 1190 Mt. Aetna Rd. Hagerstown, Md. 21740

State Registrar

31. Date filed (Month, Dey, Year): JAN 24 2001
32. Registrer's Signature: James D Sparks

DHMH 16 Rev 6/95

ORIGINAL

1903 - SMAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ADDEND ITEM: #

Certificate of Death

Reg. No. 2001 02780

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Glen Earl GARDNER

2. Date of Death (Month, Day, Year): January 17, 2001

3. Time of Death: 2:15 a.m.

4a. Facility Name *(If not institution, give street and number)*: 7515 Lake Shore Drive

4b. City, Town, or Location of Death: Owings

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 220 40 6082

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 27, 1943

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Owings

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7515 Lake Shore Drive

10f. Zip Code: 20736

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Safety Officer

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Earl Gregory Gardner

18. Mother's Name *(First, Middle, Maiden Surname)*: Glenda Winona Wilson

19a. Informant's Name/Relationship *(Type, Print)*: Patricia D. Gardner (wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as 10 above

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* entombment

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Southern Mem. Gardens

Date: Jan. 20, 2001

20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreas Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Bruce A. Silver, MD

29c. License number: D21463

29d. Data signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRUCE A. SILVER, MD 110 HOSPITAL RD, PRINCE FREDERICK, MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02781

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNEST CLAYTON GREEN
2. Date of Death (Month, Day, Year): 1/11/01
3. Time of Death: 7:30 AM
4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONT

Funeral Director

5. Social Security Number: 578-09-6167
6. Sex: [X] 1 M [ ] 2 F
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/31/10
9. Birthplace (State or Foreign Country): SALEM, NJ

Usual Residence of Decedent

10a. State: MD
10b. County: PG
10c. City, Town or Location: HYATTSVILLE
10d. Inside City Limits: [X] 1 Yes [ ] 2 No
10e. Street and Number: 6500 RIGGS ROAD
10f. Zip Code: 20783
10g. Citizen of What Country?: USA

11. Marital Status: [ ] 1 Never Married [ ] 2 Married [X] 3 Widowed [ ] 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? [ ] 1 Yes [X] 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) [ ] 1 Yes [X] 2 No Specify:
14. Race - American Indian, Black, White: AFRO-AMERICAN Specify:

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4or 5+): NONE
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CUSTODIAN
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): CHARLES GREEN
18. Mother's Name (First, Middle, Maiden Surname): BERTHA (UNK)

19a. Informant's Name/Relationship (Type, Print): DONALD GREEN (SON)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 31 APPLE VALLEY ROAD, STANFORD, CONN. 06903

20a. Method of Disposition: [X] 1 Burial [ ] 2 Cremation [ ] 3 Removal from State [ ] 4 Donation [ ] 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEM PK CEM Date: 1/17/01
20c. Location - City or Town, State: LANDOVER, MD.

21. Signature of Funeral Service Licensee: #CC0273 Juan Smith
22. Name and Address of Facility: JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS — DAYS

Due to (or as a consequence of):
b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Atherosclerosis

23b. Did tobacco use contribute to the cause of death? [ ] 1 Yes [ ] 2 No [ ] 3 Probably [X] 4 Unknown

24a. Was an autopsy performed? [ ] 1 Yes [X] 2 No
24b. Were autopsy findings available prior to completion of cause of death? [ ] 1 Yes [X] 2 No

25. Was case referred to medical examiner? [ ] 1 Yes [X] 2 No
26. Place of Death (Check only one): Hospital: [X] 1 Inpatient [ ] 2 ER/Outpatient [ ] 3 DOA; Other: [ ] 4 Nursing Home [ ] 5 Residence [ ] 6 Other (Specify)

27. Manner of Death: [X] 1 Natural [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigation [ ] 6 Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? [ ] 1 Yes [ ] 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [X] 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] 2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible]
29c. License number: D 42403
29d. Date signed (Month, Day, Year): 1/11/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJ MATHUR 106 IRVING STREET NW WASHINGTON DC 20010

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Jennie D. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

6

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02782

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Dennis Glasco

2. Date of Death Month / Day / Year: January 11 2001

3. Time of Death: 9:45 P.M.

4a. Facility Name *(If not institution, give street and number)*: VAMHCS FORT HOWARD DIVISION

4b. City, Town, or Location of Death: FORT HOWARD

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 577-51-0982

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 08-05-39

9. Birthplace *(State or Foreign Country)*: WASHINGTON D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4716 John Street

10f. Zip Code: 20746

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 12 | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Disabled

16b. Kind of Business/Industry: None

17. Father's Neme *(First, Middle, Last)*: Cleopas Glasco

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Hampton

19a. Informent's Name/Relationship *(Type, Print)*: Kenneth Glasco / Brother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4716 John Street, Suitland, MD 20746

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Chesapeake Crematory

Date: 1/15/01

20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Larry L Simmons

22. Name and Address of Facility: Pope Funeral Homes, 5538 Marlboro Pike, Forestville, MD 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximeta Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ESOPHAGEAL CANCER — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was casa referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the causa(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and dua to the cause(s) and manner stated.

29b. Signeture and title of certifier: Marcos B. Galicia M.D.

29c. License number: D0015698

29d. Date signed *(Month, Day, Year)*: Jan. 12, 2001

30. Name snd address of person who completed cause of death (Item 23a) (Type, Print): MARCOS B. GALICIA, M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: Bonnie B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0036

GLASCO, JAMES D.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02783

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSSIE GRAVES, JR
2. Date of Death (Month, Day, Year): JANUARY 16, 2001
3. Time of Death: 7:24 PM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 578-54-9211
6. Sex: [X] M [ ] F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov.25,1939
9. Birthplace (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4702 Mercury Drive
10f. Zip Code: 20853
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - Americen Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electronic Tech
16b. Kind of Business/Industry: NIST

17. Father's Name (First, Middle, Last): Rossie M. Graves, Sr.
18. Mother's Name (First, Middle, Maiden Surneme): Parthenia Griffith

19a. Informant's Name/Relationship (Type, Print): Thelma L. Graves (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code): 4702 Mercury Dr., Rockville, MD 20853

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cem. | Date: 1/22/01
20c. Location - City or Town, State: Silver Spring,MD

21. Signature of Funeral Service Licensee: George L. Snowden
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Deeth
Immediate Ceuse (Finel disaase or condition resulting in deeth) a.	Acute Myocardial Infarction	minutes
Due to (or es e consequence of): b.	Atherosclerotic Coronary Artery Disease	years
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Diabetes Mellitus	years
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yas 2 [ ] No

25. Was cese referred to medical examiner? [X] Yes 2 [ ] No
26. Plece of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Carle D. Ley MD
29c. Licansa number: D54747
29d. Data signad (Month, Day, Year): January 16, 2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Carle D. Ley MD, 9210 Corporate Blvd, Suite 210, Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

01-204-033
PaUL R. HURST
JVW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02784

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Paul Ray Hurst, Sr.

2. Date of Death: Month JANUARY Day 12 Year 2001

3. Time of Death: 11:50 P.M.

4a. Facility Name (If not institution, give street and number): 6300 SHERIFF ROAD

4b. City, Town, or Location of Death: LANDOVER

4c. County of Death: PRINCE GEORGE 'S

Funeral Director

5. Social Security Number: 403-62-4815

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 51 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 6, 1949

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: KY

10b. County: Kenton

10c. City, Town or Location: Covington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9494 Locust Pike

10f. Zip Code: 41015

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver

16b. Kind of Business/Industry: King Trucking

17. Father's Name (First, Middle, Last): Dewey Hurst

18. Mother's Name (First, Middle, Maiden Surname): Sarah Jane Sumner

19a. Informant's Name/Relationship (Type, Print): Paul Ray Hurst,Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9494 Locust Pike, Covington,Kentucky 41015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hill Crest Cemetery

Date: 1/19/01

20c. Location - City or Town, State: Dry Ridge,Kentucky

21. Signature of Funeral Service Licensee: Philip D Rinaldi

22. Name and Address of Facility: Philip D.Rinaldi Funeral Service 11818 New Hampshire Ave.Silver Spring,Md.

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 13,2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Limit: Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02785

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Betty Jean Hancock
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 5:00 am
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 232-84-8423
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 20, 1950
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bladensburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4107 55th Avenue
10f. Zip Code: 20710
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): Theodore Roosevelt
18. Mother's Name (First, Middle, Maiden Surname): Nannie Leola Hoops

19a. Informant's Name/Relationship (Type, Print): Daniel David Hancock, Jr. - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4107 55th Avenue, Bladensburg, MD 20710

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 01/19/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. Metastatic Carcinoma of Lung

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D50015
29d. Data signed (Month, Day, Year): January 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sary Beidas, M.D., 3001 Hospital Drive, Cheverly, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon as possible.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02786

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RIGOBERTO HERNANDEZ
2. Date of Death (Month, Day, Year): JANUARY 15, 2001
3. Time of Death: 2114
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 212-37-9281
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 38 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN 4, 1963
9. Birthplace (State or Foreign Country): MEXICO

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: RIVERDALE
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5300 56TH AVENUE
10f. Zip Code: 20737
10g. Citizen of What Country? MEXICO

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☒ Yes 2☐ No Specify: MEXICAN
14. Race - American Indian, Black, White, etc. Specify: HISPANIC

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+)
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DRIVER
16b. Kind of Business/Industry: APOLLO ICE

17. Father's Name (First, Middle, Last): IGNACIO HERNANDEZ
18. Mother's Name (First, Middle, Maiden Surname): PETRA MEJIA

19a. Informant's Name/Relationship (Type, Print): ROLANDO HERNANDEZ/BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5408 KENILWORTH AVE. RIVERDALE, MD 20737

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SANTA MARIA CEMETERY
Date: 1/22/01
20c. Location - City or Town, State: OCOYOACAC, MEXICO

21. Signature of Funeral Service Licensee: Nicholas D. Rinaldi
22. Name and Address of Facility: NICHOLAS D. RINALDI FUNERAL SERVICE 11819 New Hampshire Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Esophageal Perforation
Due to (or as a consequence of):
b. Caustic ingestion of Drano

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): December 16, 2000
28b. Time of Injury: 0059 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: Patient drank a can of Drano
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Spouse's home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 5300 56th Avenue Riverdale, Maryland 20737

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Salvador Sylvester, DO
29c. License number: H0055727
29d. Date signed (Month, Day, Year): January 18, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02787

HOLLAND, C. VINCENT
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CARROLL VINCENT HOLLAND
2. Date of Death: Month JANUARY Day 24, Year 2001
3. Time of Death: 4:05 A.M.
4a. Facility Name (If not institution, give street and number): Berlin Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 216-09-9300
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 95 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 7/20/1905
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 314 S. Main St.
10f. Zip Code: 21811
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specity Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:
14. Raca - American Indian, Black, Whita, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vice President
16b. Kind of Business/Industry: Bank

17. Father's Name (First, Middle, Last): Charles H. Holland
18. Mother's Name (First, Middle, Maiden Surname): Minnie K. Powell

19a. Informant's Name/Relationship (Type, Print): W. Kirk Burbage
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 William st. Berlin, MD 21811

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or othar place): Evergreen Cemetery
Date: 1/26/01
20c. Location - City or Town, Stata: Berlin, MD

21. Signature of Funeral Service Licensee: W. Kirk Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Entar only disease, or complications that caused the death. Do not entar the moda of dying, such as cardiac or respiratory errest, shock, or heart failure. List only ona cause on aach line.

Approximata Interval Between Onset and Death

Immediate Causa (Final disease or condition resulting in death)
a. Acute Myocardial Infarct hours

Due to (or as a consequence of):
b. Coronary Antherosclerosis Yrs

Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last
Due to (or as a consequanca of):
c. Diffuse General Atherosclerosis

Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Congestive Hearth Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Wara autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarrad to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only ona): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datermined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledga, daath occurrad at tha tima, data and placa, and due to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurrad at the tima, data and placa, and due to the causa(s) and manner stated.
29b. Signature and titla of certifiar
29c. License number: D02026
29d. Date signed (Month, Day, Year): 1-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Donna B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

12

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02788

HOLLAND, ROBERT L.
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT LEE HOLLAND
2. Date of Death Month / Day / Year: JANUARY 20, 2001
3. Time of Death: 4:45 A.M.

4a Facility Name *(If not institution, give street and number)*: Berlin Nursing and Rehabilitation Center
4b. City, Town, or Location of Death: Berlin
4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 215-20-1255
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10/3/1925
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Berlin
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10 Fisherman Dr.
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician
16b. Kind of Business/Industry: Chemical Co.

17. Father's Name *(First, Middle, Last)*: William L. Holland
18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Daugherty

19a. Informant's Name/Relationship *(Type, Print)*: Kathleen Holland/ Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10 Fisherman Dr. Berlin, MD 21811

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dennis Cemetery
Date: 1/23/01
20c. Location - City or Town, State: Willards, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Burbage Funeral Home, 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial infarction

Due to (or as a consequence of):
b. Coronary Artherosclerosis — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
terminal Stage Parkinsm
Diffuse Artherosclerosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [XX] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.
29b. Signature and title of certifier: [signature]
29c. License number: D02026
29d. Date signed *(Month, Day, Year)*: 1-21-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD. 21811

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

10+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02789

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL DAVIS HALL

2. Date of Death: Month January Day 17 Year 2001

3. Time of Death: 1515

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-30-8249

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 10, 1933

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: PARSONSBURG

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 32268 OLD OCEAN CITY RD.

10f. Zip Code: 21849

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U,S. Armad Forces? 1 [ ] Yes 2 [X] No If Yas, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): POULTRY GRADER

16b. Kind of Business/Industry: DEPT. OF AGRICULTURE

17. Father's Name (First, Middle, Last): ORLANDO HALL

18. Mother's Name (First, Middle, Maiden Surname): ELLA DAVIS

19a. Informant's Name/Relationship (Type, Print): BETTY ANN HALL - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 32268 OLD OCEAN CITY RD. PARSONSBURG, MD 21849

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DALE CEMETERY

Date: 1/22/01

20c. Location - City or Town, State: WHALEYVILLE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ B. Rentz Phipps, CFSP

22. Name and Address of Facility: 705 E. MAIN ST. 21804 BOUNDS FUNERAL HOME, INC. SALISBURY, MD

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Staphylococcal Sepsis — 4 days

Due to (or as a consequence of):

b. Chronic lymphocytic leukemia — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Homa 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.

29c. Licensa number: D30690

29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): James E. Martin, M.D. 145 E. Carroll St., Salisbury MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: ▶ Denise D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Paul Hall 214-30-8249

10 DA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02790

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Alice Reaves Houck

2. Date of Death (Month, Day, Year): JANUARY 15, 2001

3. Time of Death: 12:56 PM

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: Havre DeGrace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 220-09-5757

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 26, 1913

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 241 Hopewell Road

10f. Zip Code: 21028

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: In home

17. Father's Name (First, Middle, Last): Joseph Jordan

18. Mother's Name (First, Middle, Maiden Surname): Julia Weaver

19a. Informant's Name/Relationship (Type, Print): Robert LeRoy Houck (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3848 Bay Road Street, Maryland 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens

Date: 1/19/01

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Cerebrovascular Accident — 15 Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Aphasia

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MIRZA A-BAIG MD

29c. License number: D43115

29d. Date signed (Month, Day, Year): 1-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 615 South Union Ave, Havre De Grace, MD 21078

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

BH

HOUCK, ALICE R.

3

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02791

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THERESA HOFFMAN

2. Dete of Deeth — Month: JANUARY Dey: 19 Year: 2001

3. Time of Death: 1435

4e. Facility Name *(If not institution, give street and number)*: The Johns Hopkins Hospital

4b. City, Town, or Location of Deeth: Baltimore City

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 219-10-4520

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Feb. 12, 1917

9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4 Leinster Garth

10f. Zip Code: 21236

10g. Citizen of Whet Country?: U.S.A.

11. Merital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 7th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tavern Owner

16b. Kind of Business/Industry: Self-Employed Tavern

17. Father's Name *(First, Middle, Last)*: Alexander DeFabio

18. Mother's Name *(First, Middle, Maiden Surneme)*: Cecilia Comi

19a. Informent's Name/Relationship *(Type, Print)*: Ms. Alexis F. Keller (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4 Leinster Garth, Baltimore, MD 21236

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cem.

Dete: 1/22/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian C. Miller

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in deeth)

a. DILATED CARDIOMYOPATHY — 5 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if sny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE — 7 YEARS.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical exeminer? 1☐Yes 2☒No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and pleca, end due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and piece, end due to tha ceuse(s) end manner steted.

29b. Signature and title of certifier: ▶ Rahul Garg MD

29c. License number: RES-000

29d. Dete signed *(Month, Day, Year)*: JANUARY 19, 2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): RAHUL GARG 600 N. Wolfe St., Baltimore, MD 21205

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrer's Signeture

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02792

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA ELIZABETH HAWTHORNE
2. Date of Death (Month, Day, Year): Jan. 20, 2001
3. Time of Death: 8:00 AM
4a. Facility Name (If not institution, give street and number): SunBridge Care of Elkton
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 215-42-1571
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/14/1911
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1528 Old Tower Road
10f. Zip Code: 21001
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown | College (1-4or 5+): — —
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): William Hawthorne
18. Mother's Name (First, Middle, Maiden Surname): Harriett Maurice Jones

19a. Informant's Name/Relationship (Type, Print): James Wallace /Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1004 Beall Drive Joppa, Maryland 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): William Watters Cem. | Date: 1/23/2001
20c. Location - City or Town, State: Cooptown, Maryland

21. Signature of Funeral Service Licensee: M. Gladden Kurtz III
22. Name and Address of Facility: E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death):
a. END STAGE DEMENTIA (ALZHEIMER'S) — 5 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Sureshchandra MD
29c. License number: D45344
29d. Date signed (Month, Day, Year): 01/20/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SURESH DHANJANI, MD, 622 S. UNION AVE, HAVRE DE GRACE, MD 21078

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

pg. 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02793

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Madeline Gertrude Hall

2. Date of Death — Month: January Day: 20, Year: 2001

3. Time of Death: 07:10PM

4a. Facility Name *(If not institution, give street and number)*: Charles County Nursing Rehab Center

4b. City, Town, or Location of Death: La Plata

4c. County of Death: Charles

Funeral Director

5. Social Security Number: 579-05-7513

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 17, 1905

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Marys

10c. City, Town or Location: Avenue

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 37335 Riversprings Road

10f. Zip Code: 20609

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cafeteria Worker

16b. Kind of Business/Industry: Board of Education

17. Father's Name *(First, Middle, Last)*: James Ernest Graves

18. Mother's Name *(First, Middle, Maiden Surname)*: Martha Ellen Long

19a. Informant's Name/Relationship *(Type, Print)*: Evelyn Conner/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 705 Silver Linden Drive, LaPlata, Maryland 20646

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charles Memorial Gardens

Date: 01-24-2001

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Williams Funeral Home, P.A. M00668 4270 Hawthorne Road, Indian Head, Maryland 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Renal Failure

Due to (or as a consequence of): Cardiomyopathy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)* — Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D28352

29d. Date signed *(Month, Day, Year)*: 1-31-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02794

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Thelma M. Houchen
2. Date of Death Month / Day / Year: January 16, 2001
3. Time of Death: 9:30 p
4e. Facility Name *(If not institution, give street and number)*: Westminster Nursing & Rehabilitation
4b. City, Town, or Location of Death: Westminster
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-05-3590
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 31, 1908
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. Stete: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1234 Washington Rd.
10f. Zip Code: 21157
10g. Citizen of What Country?: USA

11. Meritei Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 6 | College (1-4or 5+): 0
16a. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Factory Worker
16b. Kind of Business/Industry: Seine Factory
17. Father's Name *(First, Middle, Last)*: William Ditty
18. Mother's Name *(First, Middle, Maiden Surname)*: Dorcas (Unknown)
19a. Informent'a Neme/Reiationship *(Type, Print)*: Donald C. Houchen (Son)
19b. Mailing Addreas *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 700 Wildlife Ct. Westminster, MD 21157
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glen Haven Memorial
Date: 1-20 2001
20c. Location - City or Town, State: Glen Burnie, MD
21. Signature of Funeral Service Licensee: John K. Apt
22. Name end Address of Feciility: Pritts Funeral Home and Chapel, P.A. 412 Washington Rd. Westminster, MD 21157

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
a. Dementia

Due to (or as a consequence of):
b. Depression

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last
Due to (or as e consequence of):
c. Dehydration

Due to (or as a consequence of):
d. Dysphagia

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.
Lacunar Infarct
Osteoporosis
Chronic Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hoapital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, offica buliding, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end piace, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piaca, and due to the cause(s) and menner stated.
29b. Signature and title of certifier: R Kanerka M.D
29c. License number: D 0054218
29d. Dete signed *(Month, Day, Year)*: 01-17-01
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): DR RAMAN B. KANERIA. 419-F Malcam drive Westminster MD 21157

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02795

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BLANCHE MARIE HUGHES
2. Date of Death Month Day Year: JAN. 18, 2001
3. Time of Death: 3:35 AM
4a. Facility Name *(If not institution, give street and number)*: CARROLL LUTHERAN VILLAGE HEALTH CARE
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 213-05-1263
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 99 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10/7/1901
9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1621 RIDGE RD.
10f. Zip Code: 21157
10g. Citizen of What Country?: USA.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MACHINE OPERATOR
16b. Kind of Business/Industry: SHOE FACTORY

17. Father's Name *(First, Middle, Last)*: GREENBERRY NULL
18. Mother's Name *(First, Middle, Maiden Surname)*: MAGGIE LITTLE

19a. Informant's Name/Relationship *(Type, Print)*: PEGGY McKINNEY- Grand-Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1687 EXETER RD., WESTMINSTER, MD. 21157

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: EVERGREEN MEM. GARDENS — Date: 1/20/01
20c. Location - City or Town, State: FINKSBURG, MD.

21. Signature of Funeral Service Licensee: Thomas D. Fletcher
22. Name and Address of Facility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Aspiration Pneumonia — twks
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Advanced Dementia, Severe COPD-Emphysema

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D37949
29d. Date signed *(Month, Day, Year)*: Jan. 18th, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alexander Bogdanchenko MD 2615 Seven River Suite #207, Westminster, MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02796

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Virginia Hoover

2. Date of Death (Month, Day, Year): January 16, 2001

3. Time of Death: 7:25pm

4a. Facility Name (If not institution, give street and number): WILLIAM HILL HEALTH CARE

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 212-05-1299

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 6 1910

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 501 DUTCHMANS LANE

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK

16b. Kind of Business/Industry: COMMUNICATIONS

17. Father's Name (First, Middle, Last): ELIJAH B. HOOVER

18. Mother's Name (First, Middle, Maiden Surname): MARIE WEBER

19a. Informant's Name/Relationship (Type, Print): PHYLLIS McCLINTOCK/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 NORTH WEST CREEK DR., STEVENSVILLE, MD 21666

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY | Date: 1-22-01

20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Joseph M. Ostrowski

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — Approximate Interval: 1 hr

Due to (or as a consequence of):

b. End Stage COPD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R A Burgoyne

29c. License number: D42816

29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RICHARD A. BURGOYNE, M.D. 607 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amende items 25,27,28a-f per PHYG794 4/12/2001 EW

Certificate of Death

Reg. No. 2001 02797

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Jeanne	M.	Harris	Jan.	19	2001	14:45

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
University of Maryland Medical System	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
104-03-9544	1☐ M 2☒ F	80 Yrs.					Jan.10,1921	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Caroline	Preston	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2731 Lusk Drive	21655	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Rudolph Kramer	Catherine Simmons

19a. Interment's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
William H. Harris/Spouse	P.O. Box 335, Preston, MD 21655

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Cambridge Crematory	1/23/01	Cambridge, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Michael F. Eskew	Framptom-Hawkins-Eskow Funeral Home, PA PO Box 43, Federalsburg, MD 21632

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Staphylococcal Sepsis	10 Days
	Due to (or as a consequence of): Respiratory Failure	10 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): Liver Failure	5 Days
	c. Due to (or as a consequence of): Coagulopathy	3 Days
	d.	

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Chronic Obstructive Pulmonary Disease

Atrial Fibrilladon, Motor Vehicle Collision

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	Dec 21,2000	1545 M	1☐ Yes 2☒ No	accident Subject involved in motor vehicle
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Road			Dover Bridge Rd-Tanyard Rd

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Steven J. Schwartz, MD	D53850	Jan. 25, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven J. Schwartz 22 S. Greene St., Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 2001	▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

2001 02798

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 6876, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORIS TRADER HANLEY			2. DATE OF DEATH (Month, Day, Year): JANUARY 23, 2001	3. TIME OF DEATH: 6:00 P.M.
4. SOCIAL SECURITY NUMBER: 220-74-8626	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 4, 1908	8. BIRTHPLACE (State or Foreign Country): Berlin, MD
9a. FACILITY NAME (If not institution, give street and number): 13008 Riggin Ridge Road		9b. CITY, TOWN OR LOCATION OF DEATH: Ocean City		9c. COUNTY OF DEATH: WORCESTER

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Ocean City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 13008 Riggin Ridge Road		10f. ZIP CODE: 21842	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: RESIDENCE	
17. FATHER'S NAME (First, Middle, Last): OSCAR TRADER (DEC.)		18. MOTHER'S NAME (First, Middle, Maiden Surname): ADA BELLE PRUITT (DEC.)	
19a. INFORMANT'S NAME (Type/Print): Winston Trader		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9520 Rockport Road Vienna, VA 22180-3446	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ENTOMBMENT	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): BUCKINGHAM CEMETERY 01-27-2001	DATE	20c. LOCATION — City or Town, State: BERLIN, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ross W. Trader		22. NAME AND ADDRESS OF FACILITY: TRADER FUNERAL HOME INC. 12 LOTUS STREET, DOVER, DELAWARE 19901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PANCREATIC MASS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. OBSTRUCTIVE JAUNDICE
DUE TO (OR AS A CONSEQUENCE OF):
c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D46257	29d. DATE SIGNED (Month, Day, Year): ▶ 1/24/01
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH-ITEM 27) (Type, Print): 9714 Heathway Drive Berlin, MD 21811		
31. DATE FILED (Month, Day, Year): JAN 26 2001	32. REGISTRAR'S SIGNATURE: Debra D. Sparks	

OHMH-18 Rev 1/89

CPS
01-0190-003
RAY HAMLETT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02799

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ray A. Hamlet II

2. Date of Death Month Day Year: January 11, 2001

3. Time of Death: 19:07

4a. Facility Name *(If not institution, give street and number)*: Maryland House of Corrections Annex

4b. City, Town, or Location of Death: Jessup

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 575-06-8563

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 23 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 1, 1977

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3506 New Hampshire Ave. NW #2

10f. Zip Code: 20010

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 years; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unemployed

16b. Kind of Business/Industry: N/A

17. Father's Neme *(First, Middle, Last)*: Ray A. Hamlet, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Grace D. Burroughs

19a. Informant's Name/Relationship *(Type, Print)*: Grace D. Foster - Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3506 New Hampshire Ave. NW #2 Washington, D.C. 20010

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Glenwood Cemetery

Dete: 1/20/2001

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Stewart

22. Name and Address of Facility: Stewart Funeral Home, Inc. 4001 Benning Rd., NE Washington, DC 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Stab wound of chest

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: 1/11/01

28b. Time of Injury: 1840 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject stabbed

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Prison

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: House of Corrections 20794

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, dete and pleca, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: OCME

29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02800

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALMA M HAIRSTON
2. Data of Death Month Day Year: January 6 2001
3. Time of Death: 11:33 PM
4a. Facility Name (If not institution, give street and number): Doctors Hospital
4b. City, Town, or Location of Death: Lanham, MD
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 225-54-3746
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): 7-23-1939
9. Birthplaca (State or Foreign Country): Martinsville, VA

Usual Residence of Decedant

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Landover Hills
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 3736 Ingalls Ave
10f. Zip Coda: 20784
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Yeer or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elamantary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired): Expeditor
16b. Kind of Businass/Industry: Private

17. Fathar's Nama (First, Middla, Last): John Kit Hairston
18. Mothar's Nama (First, Middle, Maiden Surname): Hattie Gibson

19a. Informant's Name/Relationship (Type, Print): Earnest Cornell Hairston/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda): 3736 Ingalls Ave Landover Hills, MD 20784

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Steta 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of camatary, cramatory or othar placa): Carver Memorial Garden
Data: 1-11-01
20c. Location - City or Town, Stata: Martinsville, MD

21. Signatura of Funeral Service Licensee
22. Nama and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complicetions that caused tha daath. Do not antar the mode of dying, such es cardiec or respiratory errast, shock, or haart failura. List only ona causa on aach lina.

Approximeta Intarval Batween Onset and Deeth

Immediata Causa (Final disaase or condition rasulting in death):
a. Acute Respiratory Failure — 11 days
Dua to (or as a consequence of):
b. Acute Bronchitis — 11 days
Dua to (or as a consequance of):
Sequentially list conditions, if any, laeding to immadiata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last
c. Chronic Obstructive Pulmonary Disease — 15 years
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying cause givan in Part I.: Acute Renal Failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Wara autopsy findings availabla prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No
26. Place of Daath (Check only one): Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify)
27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined
28a. Dete of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, ferm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar (Check only one): 1☒ **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigetion, in my opinion, daath occurred at the time, dete and piece, end due to tha cause(s) and mannar stated.

29b. Signeture and title of certifier: Louis Steinberg MD
29c. Licanse number: D0012015
29d. Date signed (Month, Dey, Year): 1-8-01

30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print): Louis Steinberg 6492 Landover Rd. Landover, MD 20785

State Registrar

31. Data filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: Jenna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completed/filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02801

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Marie Hooker

2. Date of Death (Month, Day, Year): January 05, 2001

3. Time of Death: 7:45pm

4a. Facility Name (If not institution, give street and number): 9211 Sandy Creek Road

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-28-0049

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 07,1918

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9211 Sandy Creek Road

10f. Zip Code: 20744

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hostess

16b. Kind of Business/Industry: Private (Mackey Co.)

17. Father's Name (First, Middle, Last): John Johnson

18. Mother's Name (First, Middle, Meiden Sumeme): Catherine Curtis

19a. Informant's Name/Relationship (Type, Print): William Hooker / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9211 Sandy Creek Road, Ft. Washington, Maryland 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 1/11/01

20c. Location - City or Town, State: Bladensburg, Maryland

21. Signature of Funeral Service Licensee: Kimberly C Burtonic

22. Name and Address of Facility: Marshall's Funeral Home 4308 Suitland Road, Suitland, Maryland 20746

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. Hepato cellular Carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Hepatitis C

2. Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: B. Srivase Chary M.D.

29c. License number: D 0051913

29d. Date signed (Month, Day, Year): 01/17/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bejjenki S. Chary, M.D. 6196 Oxon HillRoad, Suite 520 Oxon Hill, MD 20745

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02802

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Lucille Hill

2. Date of Death (Month, Day, Year): 1/12/2001

3. Time of Death: 2:30PM

4a. Facility Name (If not institution, give street and number): Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 229-32-0284

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 29, 1928

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7314 Powhattan Street

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Benjamin Harrison Cleek

18. Mother's Name (First, Middle, Maiden Surname): Bertha Jane Gum

19a. Informant's Name/Relationship (Type, Print): Christine Dunmore - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1885 Disney Estates Circle, Severn, MD 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Cedar Hill Cemetery

Date: 01/16/01

20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Dorothy Leary Witt

22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. INTRACEREBRAL HEMORRHAGE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. MYOCARDIAL INFARCTION.

Due to (or as a consequence of):

c. PULMONARY EDEMA.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Berhane

29c. License number: D005703

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): TSION BERHANE. 3001 HOSPITAL DRIVE CHEVERLY, MD 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: B. Sparks

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02803

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Thomas Patrick Hormuth

2. Date of Death: Month JANUARY Day 24 Year 2001

3. Time of Death: 8:20 AM

4a. Facility Name (If not institution, give street and number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 211-30-0353

6. Sex: 1 ■ M 2 ☐ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): April 22, 1939

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1 ☐ Yes 2 ■ No

10e. Street and Number: 35711 Golf Course Drive

10f. Zip Code: 20659

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ■ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 ☐ No

If Yes, Give Year or Dates: 1968 1987

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ■ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 2

College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Commissioned Officer

16b. Kind of Business/Industry: United States Navy

17. Father's Name (First, Middle, Last): Elmer Patrick Hormuth

18. Mother's Name (First, Middle, Maiden Surname): Klare Kress

19a. Informant's Name/Relationship (Type, Print): Sandra L. Hormuth / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35711 Golf Course Drive, Mechanicsville, MD 20659

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National

Date: 2-6-01

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, JR M00052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — sec

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ___

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D14285

29d. Date signed (Month, Day, Year): 1-24-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM D. BOYD II M.D. POST OFFICE BOX 1753 LEONARDTOWN, MD. 20650

State Registrar

31. Date filed (Month, Day, Year): JAN 29 2001

32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

THOMAS PATRICK HORMUTH

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02804

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Woodrow Claiborne Henderson
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 10:39 a.m.
4a. Facility Name (If not institution, give street and number): St. Mary's Nursing Center
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 231-50-8897
6. Sex: 1 ■ M 2 ☐ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 7, 1914
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: California
10d. Inside City Limits: 1 ☐ Yes 2 ■ No
10e. Street and Number: 23140 Cobblestone Lane
10f. Zip Code: 20619
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ■ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ■ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 8
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dentist
16b. Kind of Business/Industry: Dentistry

17. Father's Name (First, Middle, Last): William Morton Henderson
18. Mother's Name (First, Middle, Maiden Surname): Irene Catherine Satterfield

19a. Informant's Name/Relationship (Type, Print): Ann Marum / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 46594 Rue Purchase Road, Lexington Park, MD 20653

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): West Hampton Cemetery
Date: 1-15-01
20c. Location - City or Town, State: Richmond, Virginia

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiopulmonary Failure	hrs
Due to (or as a consequence of): b.	Congestive Heart Failure	days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Cardiomyopathy	wks
Due to (or as a consequence of): d.	Coronary Artery Disease	yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ■ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ■ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ■ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ■ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ■ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Jarboe, M.D.
29c. License number: D 06419
29d. Date signed (Month, Day, Year): 1-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James P. Jarboe, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: P. Jarboe

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02805

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Lola Hawes
2. Date of Death (Month, Day, Year): JANUARY 28, 2001
3. Time of Death: 7:25AM
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 577-48-9407
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 21, 1914
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 40335 Drury Lane
10f. Zip Code: 20650
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Walter Dyer MacEwen
18. Mother's Name (First, Middle, Maiden Surname): Grace Mildred Eppley

19a. Informent's Name/Reletionship (Type, Print): William E. Hawes (Spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 40335 Drury Lane, Leonardtown, Maryland 20650

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Christ Episcopal Cemetery
Date: 1/31/2001
20c. Location - City or Town, State: Chaptico, Maryland

21. Signature of Funeral Service Licensee: Mary Rizzo NO 114
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiogenic Shock — 1-3 days
Due to (or as a consequence of):
b. Severe Congestive Heart failure
Due to (or as a consequence of):
c. Coronary artery Disease — years
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Valvular Heart Disease, COPD
Pulmonary Hypertension, Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D19917
29d. Date signed (Month, Day, Year): 1/29/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. JAMES BOYD CALIFORNIA, MD. 20619

State Registrar

31. Date filed (Month, Day, Year): JAN 31 2001
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NMAE: GRACE LOLA HAWES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02806

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marian Alma Hutman
2. Date of Death (Month, Day, Year): JANUARY 08, 2001
3. Time of Death: 5:10PM
4a. Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 578-28-9286
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 20,1926
9. Birthplace (State or Foreign Country): Washington,DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 38998 Lupes Court
10f. Zip Code: 20659
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify: X
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: At Home

17. Father's Name (First, Middle, Last): John E. Niess
18. Mother's Name (First, Middle, Meiden Surneme): Marian Mann

19a. Informant's Name/Relationship (Type, Print): Michael T. Hutman, Jr. spouse
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 38995 Lupes Court, Mechanicsville, Maryland 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Maryland Veterans Cemetery
Date: January 16,2001
20c. Location - City or Town, Stata: Cheltenham,Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A., 22955 Hollywood Road, P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approxtmete Interval Between Onset and Death

Immediate Cause (Finei disease or condition resulting in death)
a. Acute Pulmonary Embolus — 12hrs

Due to (or as a consequence of):
b. Severe Chronic Obstructive Pulmonary Disease years

Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial fibrillation
Recent subendocardial Myocardial infarction
Congestive Heart Failure, Hypothyroidism

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Retural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) and menner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: D19917
29d. Date signed (Month, Day, Year): 1/9/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. JAMES BOYD CALIAFORNIA ,MD. 20619

State Registrar

31. Date filed (Month, Day, Year): JAN 11 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: MARIAN ALMA HUTMAN

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02807

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLIFFORD FLETCHER HIBBLE, SR.

2. Date of Death: Month JANUARY Day 6 Year 2001

3. Time of Death: 3;35 PM

4a. Facility Name (If not institution, give street and number): ST. MARY'S HOSPITAL

4b. City, Town, or Location of Death: LEONARDTOWN

4c. County of Death: ST. MARY'S

Funeral Director

5. Social Security Number: 215-14-7563

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): NOV. 18, 1920

9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ST. MARY'S

10c. City, Town or Location: MECHANICSVILLE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 35826 ARMY-NAVY DRIVE

10f. Zip Code: 20659

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: '42-'45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PROCUREMENT SPECIALIST

16b. Kind of Business/Industry: ELECTRIC COMPANY

17. Father's Name (First, Middle, Last): CLARENCE UPSHER HIBBLE

18. Mother's Name (First, Middle, Maiden Surname): MARION ALICE DYER

19a. Informant's Name/Relationship (Type, Print): ELLEN L. HIBBLE / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35826 ARMY-NAVY DR. MECHANICSVILLE, MD 20659

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GATE OF HEAVEN

Date: JAN. 10, 2001

20c. Location - City or Town, State: SILVER SPRING, MD

21. Signature of Funeral Service Licensee: Joseph Butler

22. Name and Address of Facility: BRINSFIELD-ECHOLS FUNERAL HOME, P.A. 30195 THREE NOTCH RD. CHARLOTTE HALL, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial infarction — Few min

Due to (or as a consequence of):

b. ESRD — Few years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Slp CVA — Few months ago

Due to (or as a consequence of):

d. Possible pneumonia

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A Shah

29c. License number: D 47066

29d. Date signed (Month, Day, Year): 1-7-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AVANI D. SHAH M.D. P.O.BOX 640 HOLLYWOOD, MD. 20636

State Registrar

31. Date filed (Month, Day, Year): JAN 10 2001

32. Registrar's Signature: Bonnie D. Smith

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CLIFFORD HIBBLE

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02808

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rachel Eileen Higgs
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 12:13
4a. Facility Name (If not institution, give street and number): Washington County Hospital
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-10-3404
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 20 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 152 Buttercup Drive
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Retail Clerk
16b. Kind of Business/Industry: Dress Shop

17. Father's Name (First, Middle, Last): Maltby G. Younkins
18. Mother's Neme (First, Middle, Maiden Surname): Ruth N. Phillips

19a. Informent's Name/Reletionship (Type, Print): Eugene T. Higgs - Son
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1437 Aiken Street Staunton, Virginia 24401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece): Brownsville Cemetery
Dete: 1/23/01
20c. Location - City or Town, State: Brownsville, Maryland

21. Signeture of Funeral Service Licansee: Fred Wentz
22. Name and Address of Feclility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): a. Gastrointestinal (bowel) infarction — 24 hrs.

Due to (or as a consequence of):

Sequentially list conditions, If any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) end manner es stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end dua to the cause(s) and manner stated.

29b. Signature and title of certifier: [illegible] Wooster
29c. License number: D 22043
29d. Date signed (Month, Dey, Year): 1-22-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Wooster 11110 Medical Campus Rd. Hag. Md 21742

State Registrar

31. Dete filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signeture: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Higgs, Rachel

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02809

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Monroe Howes
2. Date of Death Month: January Day: 25 Year: 2001
3. Time of Death: 3:39 a.m.
4a. Facility Name *(If not institution, give street and number)*: 4944 Dogwood Street
4b. City, Town, or Location of Death: Shady Side
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215 40 7080
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 16, 1940
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Shady Side
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4944 Dogwood Street
10f. Zip Code: 20764
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: waterman
16b. Kind of Business/Industry: seafood

17. Father's Name *(First, Middle, Last)*: Milton Monroe Howes
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Thelma Ford

19a. Informent's Name/Relationship *(Type, Print)*: Mrs. Marion K. Howes, spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as # 10 a-f above

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Woodfield Cemetery
Date: 1-29-01
20c. Location - City or Town, State: Galesville, MD

21. Signature of Funeral Service Licensee: ▶ William R. [illegible]
22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. metastatic pancreatic carcinoma — 5 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Neturat 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Ptace of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: ▶ [illegible]
29c. License number: MD D0056024
29d. Data signed *(Month, Day, Year)*: January 25 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth L. Abbott 600 Ridgely Ave # 231 Annapolis MD 21401

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02810

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Buster Leroy Holland

2. Date of Death (Month, Day, Year): January 16 2001

3. Time of Death: 8:08 pm

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 215-38-6964

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 12, 1940

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1820 C Copeland Street

10f. Zip Code: 21401

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bricklayer

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Wilmer Holland

18. Mother's Name (First, Middle, Maiden Surname): Beatrice Greene

19a. Informant's Name/Relationship (Type, Print): Cheryl Holland/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 819 C Betsy Court Annapolis, MD 21401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ernestine Jones Cemetery

Date: 1/20/01

20c. Location - City or Town, State: Chesapeake Beach, MD

21. Signeture of Funeral Service Licensee: Sharon A. Sewell

22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple injuries with complications

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Cardiac arrest

Cervical osteomyelitis

motor vehicle accident

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 9/14/00

28b. Time of Injury: 1355 M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: SUBJECT WAS A PEDESTRIAN STRUCK BY A MOTOR VEHICLE

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): FAYETTE AND CAROLINE STS BALTIMORE, MD

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: C. John Sperati, M.D.

29c. License number: RES-000

29d. Date signed (Month, Day, Year): January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. John Sperati, M.D. Johns Hopkins Hospital 600 North Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02811

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Afton Ashworth Henrichsen
2. Date of Death Month Day Year: January 8, 2001
3. Time of Death: 5:30 PM
4a. Facility Name *(If not institution, give street and number)*: 3330 N. Leisure World Blvd., #416
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 530-07-6845
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Houra / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 11, 1916
9. Birthplace *(State or Foreign Country)*: Utah

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3330 N. Leisure World Blvd., Apt. 416
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Merital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Thomas Evan Ashworth
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Naomi Emery

19a. Informent's Neme/Reletionship *(Type, Print)*: Richard E. Henrichsen / Son
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2 Stoneyhurst Court, Olney, Maryland 20837-1330

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Pleca of Disposition *(Neme of cemetery, cremetory or other piece)*: Parklawn Memorial Gard. | Dete: 01/13/01
20c. Location - City or Town, Stete: Rockville, Maryland

21. Signature of Funeral Service Licensee: James D. Schwartz
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset and Deeth
Immediate Cause (Finel diseese or condition resulting in deeth) a.	Ischemic Cardiomyopathy	7 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Lest: b.	Coronary Artery Disease	7 years
Due to (or es e consequence of):		
c.		
Due lo (or es a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Breast Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dele end place, and due lo the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signeture end litle of certifier: W.O. Lewis MD
29c. License number: D31958
29d. Date signed *(Month, Day, Year)*: JANUARY 9, 2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print): 3305 North Leisure World Boulevard, Silver Spring, MARYLAND 20906

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signeture: Geneva G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

(10)

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02812

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jessie Freeman Hudgins
2. Date of Death Month Day Year: 01-10-01
3. Time of Death: 3:50pm
4a. Facility Name *(If not institution, give street and number)*: 3900 39th Street
4b. City, Town, or Location of Death: Brentwood
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 224 22-7630A
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 04-20-23
9. Birthplace *(State or Foreign Country)*: N.C.

Usual Residence of Decedent

10a. State: Md
10b. County: Prince George
10c. City, Town or Location: Brentwood
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3900 39th Street
10f. Zip Code: 20722
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Jessie Hudgins
18. Mother's Name *(First, Middle, Maiden Surname)*: Louise Nicholson

19a. Informant's Name/Relationship *(Type, Print)*: Esther M. Wiggins
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3900 39th St. Brentwood, Md 20722

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olive Cemetery
Date: 1-13-01
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: James E. Williams
22. Name and Address of Facility: The House Of Williams 5732 Georgia Ave N.W. Washington, DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. COLON CANCER — 2 months
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D41715
29d. Date signed *(Month, Day, Year)*: 1-12-01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CHIRA VENKATRAMAN MD — 6201 GREENBELT ROAD #13 COLLEGE PARK MD 20740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02813

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph F. Harrison
2. Date of Death (Month, Day, Year): January 10, 2001
3. Time of Death: 18:58
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 220-38-1661
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 28, 1943
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Capital Heights
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1109 Adeline Way
10f. Zip Code: 20743
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance
16b. Kind of Business/Industry: Government Printing Office Federal Government

17. Father's Name (First, Middle, Last): Joseph A. Harrison
18. Mother's Name (First, Middle, Maiden Surname): Virginia Franklin

19a. Informent's Name/Relationship (Type, Print): Mrs. Mary T. Thompson (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1511 Warren Avenue Landover, Maryland 20785

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans' Cemetery
Date: 1/18/2001
20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Rollins Funeral Home, INc. 4339 Hunt Place, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Septicemia, Shock.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. End Stage renal disease
Due to (or as a consequence of):
c. Acute respiratory insufficiency
Due to (or as a consequence of):
d. Status Epilepticus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Left AKA.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [XX] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D-25640
29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Khosrow Davachi, M.D. 1328 Southern Avenue, S.E. #202 Washington, D.C. 20032

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Harrison, Joseph Star @ 1858 Dr. Davachi 01-10-01

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02814

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilbur Stephenson HOPE
2. Date of Death (Month, Day, Year): January 6 2001
3. Time of Death: 2:18 pm
4a. Facility Name (If not institution, give street and number): Doctors Hospital
4b. City, Town, or Location of Death: LANHAM
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-57-4465
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 7, 1967
9. Birthplace (State or Foreign Country): GUYANA

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: LANHAM
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 4207 KINMOUNT ROAD
10f. Zip Code: 20706
10g. Citizen of What Country?: GUYANA

To Be Completed by Funeral Director

11. Marital Status: 1☑ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR Harbor Department
16b. Kind of Business/Industry: TRANSPORTATION
17. Father's Name (First, Middle, Last): ISSAC HOPE
18. Mother's Name (First, Middle, Maiden Surname): Joy SAMUELS
19a. Informant's Name/Relationship (Type, Print): Joy SAMUELS / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4207 KINMOUNT ROAD LANHAM MD 20706
20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLENWOOD Cemetery | Date: JAN 8, 2001
20c. Location - City or Town, State: WASHINGTON DC
21. Signature of Funeral Service Licensee: ▶ Joseph B. Butler Jr.
22. Name and Address of Facility: SAM Butler and Sons Funeral Home 716 Kennedy St. NW WASHINGTON DC 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. cardiopulmonary arrest
Due to (or as a consequence of):
b. primary pulmonary hypertension
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. cor pulmonale
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Cynthia Crawford-Green, M.D.
29c. License number: D27650
29d. Date signed (Month, Day, Year): Jan. 06. 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Cynthia Crawford-Green, M.D. 8118 Goodluck Rd. Lanham, MD 20706

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Wilbur Stephenson Hope

(3)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02815

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Harold E. Hackett	January 13, 2001	11:02 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Washington Adventist Hospital	Takoma	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
211-09-1274	1☒ M 2☐ F	80 Yrs.			March 27, 1920	Pennsylvannia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Prince Georges	Takoma	1☐ Yes 2☐ No XX

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7226 15th Ave	20912	United States America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	☒ Yes 2☐ No If Yes, Give Year or Dates: July 1943	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
12		Telephone Repairman	Telephone Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Harold Hackett	Melis Nicholson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Elizabeth T. Hackett	7226 15th Ave. Takoma Maryland 20912

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Fort Lincoln	1/18/2001	Brentwood

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Thomas Wells	Fort Lincoln 3401 Bladensburg Road Brentwood Maryland 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerosis	
	Due to (or es e consequence of):	
Sequentially tist conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence ot):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown XX

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No XX	1☐ Yes 2☐ No

25. Wes case referred to medicat examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one)	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete and piece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner steted.	▶ Charles M Benner	D31563	January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11251 Lockwood Drive, Silver Spring, Md 20901------Dr. Charles M. Benner; MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 19 2001	▶ Bonnie G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02816

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: WILIRENE DOLORES HETTENHOUSER
2. Data of Death (Month, Day, Year): January 14, 2001
3. Tima of Death: 10:00A.

4e Facility Neme *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Sociel Security Number: 579-22-9451
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Yeer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Dec.3,1922
9. Birthplaca *(Stata or Foraign Country)*: Washington,D.C.

Usual Residance of Decedent

10a. Stata: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Laurel
10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street snd Number: 3279 Sudlersville South
10f. Zip Code: 20724
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcea? 1☐ Yas 2☒ No If Yas, Giva Yeer or Detea:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12): 12 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: own home

17. Fathar's Nama *(First, Middla, Last)*: Wilbur Barton
18. Mothar's Nama *(First, Middle, Maiden Surnama)*: Irene LaSalle

19a. Informant's Name/Ralationship *(Type, Print)*: John W. Hettenhouser - son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: same as #10a - 10g

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cematary, crametory or othar placa)*: Fort Lincoln Cemetery
Data: 1/18/2001
20c. Location - City or Town, Stata: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Donald V B agwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Pert1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda ot dying, such as cardiac or raspiratory arrest, shock, or heert tailure. List only one causa on aach line.

Approximate Interval Batween Onsat and Death

Immediata Causa (Finel diseasa or condition resulting in daath)
a. Myocardial Infarction — 4 days

Dua to (or as a consequance ot):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Ceuse (Diseasa or Injury that initiated evants rasulting in daath) Lest
b.
Due to (or es a consequence ot):
c.
Due to (or es a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

End Stage Renal Disease

Diabetes

23b. Did tobacco use contributa to the causs of death? 1☐ Yss 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Wes case retarred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Residanca 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Neturel 2☐ Accidant 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred

28e. Place of Injury - At home, ferm, straet, tactory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowledge, deeth occurred at the time, data and place, and dua to the cause(s) and mennar as stated. 2☐ **Medical Examiner**: On the basis of examinetion snd/or invastigation, in my opinion, death occurred at the tima, dete and place, snd due to tha cause(s) and manner steted.

29b. Signatura end title of certifier: ▶ Andrew Kundrat M.D.
29c. Licensa number: D36716
29d. Data signad *(Month, Day, Year)*: January 14, 2001

30. Nama snd addrass of person who completed cause of deeth (Item 23a) (Type, Print): Andrew Kundrat, M.D. 8317 Cherry Lane Laurel, Maryland 20707

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signatura: ▶ G. Sparks

DHMH 16 Rsv 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02817

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marie A. Hale
2. Date of Death Month Day Year: Jan. 15, 2001
3. Time of Death: 6:08 P.M.
4e. Facility Name (If not institution, give street and number): Heartland Assisted Living
4b. City, Town, or Location of Death: Severna Park
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 076 16 0242
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 26, 1920
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Eldersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 6011 Cedar Court
10f. Zip Code: 21784
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Telephone Operator
16b. Kind of Business/Industry: AT&T

17. Father's Name (First, Middle, Last): Mauro Provenzano
18. Mother's Name (First, Middle, Maiden Surname): Olga Ria Barba

19a. Informant's Name/Relationship (Type, Print): Stefanie Pesce Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1726 Foxdale Court Crofton Maryland 21114

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Poughkeepie Rural Cemetery | Date: Jan. 19, 2001
20c. Location - City or Town, State: Poughkeepie N.Y.

21. Signature of Funeral Service Licensee: Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Multiple Myeloma — months

Due to (or as a consaquance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequenca of):

c. Due to (or as e consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☑ Other (Specify) assisted living

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D-50725
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jennifer Riedinger MD 479 Jumpers Hole Severna Park MD 21146

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: pervus G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28d-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02818

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip Henry Hudson
2. Data of Death (Month, Day, Year): January 14, 2001
3. Tima of Death: 1648 PM
4a. Facility Name (If not institution, give street and number): Bowie Health Center
4b. City, Town, or Location of Death: Bowie
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 183 34 9335
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 9, 1942
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 2815 Bosworth Lane
10f. Zip Code: 20715
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1966
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Educational Administrator
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Philip Hudson
18. Mother's Name (First, Middle, Maiden Surname): Eva Clayton

19a. Informant's Name/Relationship (Type, Print): Edna Marie Hudson Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2815 Bosworth Lane Bowie Maryland 20715

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: Jan. 19, 2001
20c. Location - City or Town, State: Alexandria Virginia

21. Signature of Funeral Service Licensee: ▶ Michael L. Boyle
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular Heart Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Salvador Sy, DO
29c. License number: H00 55927
29d. Dele signed (Month, Day, Year): January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Salvador Sy 9501 Hospital Drive, Cheverly, Maryland 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02819

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WALTER GEORGE HENRY
2. Data of Death Month Day Year: JANUARY 19, 2001
3. Time of Death: 5:40AM
4a. Facility Name (If not institution, give street and number): CHESAPEAKE WOODS CENTER
4b. City, Town, or Location of Death: CAMBRIDGE
4c. County of Death: DORCHESTER

Funeral Director

5. Social Security Number: 214-07-8489
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Houra / Min.
8. Data of Birth (Month, Day, Year): APRIL 1,1915
9. Birthplace (State or Foreign Country): MARYLAND

Usual Rasidanca of Decedant

10a. Stata: MARYLAND
10b. County: DORCHESTER
10c. City, Town or Location: CAMBRIDGE
10d. Insida City Limits: 1 [ ] Yes 2 [X] No

10a. Street and Number: 5302 BUCKTOWN ROAD
10f. Zip Coda: 21613
10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decadant Evar in U.S. Armad Forces? 1 [ ] Yas 2 [X] No If Yas, Giva Yeer or Detas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No Specify:
14. Race - American Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 6 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): CARPENTER
16b. Kind of Businass/Industry: CONSTRUCTION

17. Fathar's Nema (First, Middle, Last): GEORGE HENRY
18. Mother's Nama (First, Middle, Maidan Surnama): EMMA FRAZIER

19a. Informent's Neme/Relationship (Type, Print): EUGENE W. HENRY/SON
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda): 115 LINTHICUM DRIVE, CAMBRIDGE, MD 21613

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramovel from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar piece): EAST NEW MARKET CEMETERY
Date: 1/24/01
20c. Location - City or Town, State: EAST NEW MARKET, MD

21. Signature of Funeral Service Licensee: Leonard W. Zeller
22. Nama and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 207, MAIN STREET, EAST NEW MARKET, MARYLAND 21631

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused tha daath. Do not entar tha moda of dying, such as cerdiac or raspiratory arrest, shock, or heert failura. List only one cause on each line.

Approximate Intarval Batween Onsat and Death

Immediata Ceusa (Final disease or condition resulting in daath):
a. Atherosclerotic heart disease — many years
Dua to (or as a consequence of):
b.
Dua to (or as a consequance of):
c.
Due to (or as e consequence of):
d.

Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disaase or Injury thet initieted evants resulting in daath) Last

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceusa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Wara autopsy findings available prior to completion of ceuse of death? 1 [ ] Yea 2 [✓] No

25. Was cesa refarred to medicel examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Homa 5 [ ] Residence 6 [ ] Othar (Specify)

27. Manner of Death: 1 [✓] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1 [✓] **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, deeth occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and Title of cartifiar: M.D
29c. Licansa number: D56659
29d. Date signed (Month, Day, Year): 1/19/01

30. Nama and addrass of person who compiated ceusa of daath (Item 23a) (Type, Print): Dr. Muhammad Afzal 300 Aurora St. Cambridge, md. 21613

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02820

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH J. JOERG

2. Date of Death Month Day Year: JANUARY 19, 2001

3. Time of Death: 0600

4a. Facility Name (If not institution, give street and number): BERLIN NURSING & REHAB. CTR.

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 135-03-9789

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12-4-16

9. Birthplace (State or Foreign Country): NJ

Usual Residence of Decedent

10a. State: MD.

10b. County: WORCESTER

10c. City, Town or Location: OCEAN PINES

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 86 WOOD DUCK CIRCLE

10f. Zip Code: 21811

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SECRETARY

16b. Kind of Business/Industry: INSURANCE

17. Father's Name (First, Middle, Last): OTTO DEBOLD

18. Mother's Name (First, Middle, Maiden Surname): ELIZABETH ZIEGLER

19a. Informant's Name/Relationship (Type, Print): LEONA WALLIS SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 86 WOOD DUCK CIR. OCEAN PINES, MD., 21811

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): RESTLAND MEM. PARK

Date: 1-22

20c. Location - City or Town, State: E. HANOVER, NJ

21. Signature of Funeral Service Licensee: John F. Ullrich

22. Name and Address of Facility: ULLRICH FUNERAL HOME BERLIN, MD., 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Acute Myocardial Infarct — 24 hours

Due to (or as a consequence of):
b. Coronary Artery disease — 7 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D02026

29d. Date signed (Month, Day, Year): 1-16-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): F. G. Anthes MD - 46 Teal Circle Berlin MD. 21811

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State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02821

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eileen Alana Jones
2. Date of Death (Month, Day, Year): JANUARY 20 2001
3. Time of Death: 12:55 pm
4a. Facility Name (If not institution, give street and number): LORIEN AT RIVERSIDE
4b. City, Town, or Location of Death: BELCAMP
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 302-28-6347
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 13, 1915
9. Birthplace (State or Foreign Country): Northern Ireland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Abingdon
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3723 Federal Lane
10f. Zip Code: 21009
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hairdresser
16b. Kind of Business/Industry: Hairdresser Shop

17. Father's Name (First, Middle, Last): John (nmn) O'Neill
18. Mother's Name (First, Middle, Maiden Surname): Nellie (nmn) McKeown

19a. Interment's Name/Relationship (Type, Print): Patricia E. Vargo / Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3723 Federal Lane, Abingdon, MD 21009

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp. | Date: 1-24-01
20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. alzheimer's disease	7 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D28339
29d. Date signed (Month, Day, Year): JANUARY 22, 2001
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): LINDA ANGLUCH 101 E Wheel Road Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WAKE: Eileen Jones

Eileen Alana Jones

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02822

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILDRED SETTLE

2. Date of Death: Month JANUARY Day 19 Year 2001

3. Time of Death: 12:10 AM

4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-09-9391

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 8, 1914

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3821 Ravenwood Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Payroll Clerk

16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Last): Conrad Edward Denhardt

18. Mother's Name (First, Middle, Malden Surname): Frieda Nagle

19a. Informant's Name/Relationship (Type, Print): Charles E. Payne, Jr. (Grandson)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9305 Avondale Rd., Baltimore, Maryland 21234

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith

Date: 1/23/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mark T. [illegible]

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death) e. MYOCARDIAL INFARCTION — UNKNOWN

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and manner as stated. 2☐ **Medicet Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Kofi A. Appiah, Resident Physician

29c. License number: P13450

29d. Date signed (Month, Day, Year): JANUARY 22, 2001

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): KOFI A. APPIAH, 5601 LOCH RAVEN BLVD, GOOD SAMARITAN HOSP., BALTIMORE

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

BH

5

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001

32. Registrer's Signature: [illegible]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02823

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Brannock Jones

2. Date of Death Month / Day / Year: JANUARY 15 2001

3. Time of Death: 1650

4a. Facility Name *(If not institution, give street and number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-22-9358

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 4, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 222 C Crocker Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Principal

16b. Kind of Business/Industry: Public Education

17. Father's Name *(First, Middle, Last)*: Edward Bowdle Jones

18. Mother's Name *(First, Middle, Maiden Surname)*: Blanche Gertrude Brannock

19a. Informent's Name/Relationship *(Type, Print)*: Lucille Jones / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 222 C Crocker Drive, Bel Air, MD 21014

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hilltop Service Corp.

Date: 1-17-01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: McComas Funeral Home, P.A. 50 W. Broadway St., Bel Air, MD 21014

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CANCER OF THE DESCENDING COLON

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: URINARY TRACT INFECTION

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 25027

29d. Date signed *(Month, Day, Year)*: JANUARY 16, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): VIJAY M. ABHYANKAR 2 NORTH AVENUE BEL AIR MD 21014

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JONES, WILLIAM B.

10

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02824

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Deta of Deeth Month Day Yaar	3. Time of Death
Julian B. Jarrell	January 24 2001	5:05 AM

4a Facility Nema (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Chestertown Nursing & Rehab Center	Chestertown	Kent

Funeral Director

5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday)	If Under 1 Yaar Months	If Under 1 Yaar Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Data of Birth (Month, Day, Yaar)	9. Birthplaca (State or Foreign Country)
207-01-8067	1☒ M 2☐ F	86 Yrs.					April 20 1914	Maryland

Usual Rasidanca of Decedant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Queen Anne	Sudlersville	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
Dogwood Village, Apt.C	21668	U.S.A.

11. Meritel Stetus	12. Was Decadent Evar in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - American Indian, Black, Whita, etc.
1☐ Naver Merriad 2☒ Married 3☐ Widowed 4☐ Divorcad	1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedant's Education (Specify only highast grade compiatad)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
09		painter and farmer	residential/

17. Fethar's Nama (First, Middla, Last)	18. Mothar's Name (First, Middle, Maidan Sumama)
William Henry Jarrell	Annie E. Todd Jarrell

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Mary Ann Bedwell/ daughter	12297 Andlot Farm Lane Worton, Maryland 21678

20a. Method of Disposition	20b. Placa of Disposition (Nama of camatary, cramatory or other place)	Data	20c. Location - City or Town, State
1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Othar (Specify)	Chesterfield Cemetery	1/27	Centreville, Maryland

21. Signature of Funeral Sarvica Licansae	22. Nama and Addrass of Facility
▶ Fleegle-Helfenbein	Fleegle-Helfenbein Funeral Home, P.A. P.O. Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Between Onsat and Deeth

Immediata Causa (Final disaasa or condition rasulting in daath)

a. CARDIO Pulmonary Arrest

Due to (or as a consequanca of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in deeth) Last

b. Respiratary Failure

Dua to (or as a consaquanca of):

c. CHronic OBStructive Pulmonary Disease

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

Poor Nutrition, Dehydration

23b. Did tobacco usa contribute to the cause of death? 1☑ Yss 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Wara autopsy findings availabla prior to complation of causa of death?
1☐ Yas 2☑ No	1☐ Yas 2☐ No

25. Wes casa referrad to medical examinar?	26. Place of Death (Check only ona)
1☐ Yas 2☑ No	Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☑ Nursing Homa 5☐ Rasidance 6☐ Other (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Yaar)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurrad
1☐ Naturel 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify)			28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one) 1☑ **Certifying Phyaician:** To the best of my knowledge, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar es stetad. 2☐ **Medicat Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at the time, data and placa, and due to tha cause(s) and mannar statad.

29b. Signatura and titla of cartifiar	29c. License number	29d. Data signad (Month, Day, Yaar)
▶ J. L. Arnold Jr. M.D.	D23889	1/25/01

30. Nama and Addrass of parson who completed causa of daath (Item 23a) (Type, Print)

John L. Arnold Jr. M.D. 223 High St. Chestertown, Md 21620

State Registrar

31. Data filed (Month, Day, Yaar)	32. Registrar's Signature
JAN 26 2001	▶ G. Sparks

DHMH 16 Rsv 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02825

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Siberia B. Johnson
2. Date of Death: Month 01 Day 11 Year 2001
3. Time of Death: 1:15AM
4a. Facility Name (If not institution, give street and number): Fort Washington Hospital
4b. City, Town, or Location of Death: Ft. Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-26-9472
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 22, 1921
9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10e. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7302 Webster Terrace
10f. Zip Code: 20744
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Private
17. Father's Name (First, Middle, Last): Vergil Gray
18. Mother's Name (First, Middle, Maiden Surname): Louvenia Wilson
19a. Informant's Name/Relationship (Type, Print): Barbara P. Hubb - Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7302 Webster Terrace, Ft. Wash., MD 20744
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
Date: 1/18/2001
20c. Location - City or Town, State: Brentwood, MD
21. Signature of Funeral Service Licensee: John T. Stewart, III
22. Name and Address of Facility: Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arrhythmia
Due to (or as a consequence of): Seizure
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of): Urinary Tract Infection
c.
Due to (or as a consequence of): Thrombocytopenia
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rheumatoid Arthritis
Cancer / Colon s/p Colectomy
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No
25. Was case referred to medicet exeminer? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Attending Physician
29c. License number: D0046374
29d. Date signed (Month, Day, Year): 1/12/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1328 Southern Ave SE #312 Washington DC 20032

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02826

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BERTHA JOHNSON

2. Date of Death: Month JANUARY Day 12 Year 2001

3. Time of Death: 2200

4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 579-03-8203

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 3, 1918

9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 19301 Watkins Mill Rd.

10f. Zip Code: 20886

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Statistician

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Gladstone Baltimore

18. Mother's Name (First, Middle, Maiden Surname): Catherine Norwood

19a. Informant's Name/Relationship (Type, Print): Joseph E. Johnson, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4705 Keppler Pl., Temple Hills, MD 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.

Date: 1/23/2001

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: John T. Stewart, III

22. Name and Address of Facility: Stewart Funeral Home, 4001 Benning Rd., N.E. Wash., D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CARDIAC ARREST	10 minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. RESPIRATORY FAILURE	1 year
Due to (or as a consequence of):		
	c. ATRIAL FIBRILLATION	1 year
Due to (or as a consequence of):		
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Attan Kasid M.D., Ph.D

29c. License number: D55054

29d. Date signed (Month, Day, Year): JANUARY 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ATTAN KASID 17519 REDLAND ROAD, ROCKVILLE, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02827

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FANNIE BEATRICE JONES
2. Date of Death (Month, Day, Year): JANUARY 11, 2001
3. Time of Death: 02:18 PM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 228-38-7419
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 8,1925
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Riverdale
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 6903 Furman Parkway
10f. Zip Code: 20737
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th | College (1-4or 5+)
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Owner

17. Father's Name (First, Middle, Last): Johnnie Hawkes
18. Mother's Name (First, Middle, Maiden Sumeme): Mary Virginia Louis

19a. Informant's Name/Relationship (Type, Print): Lewis Jones/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6903 Furman Parkway, Riverdale, MD 20737

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel trom Stete 4☐ Donetion 5☐ Other (Specify)
20b. Place ot Disposition (Name of cemetery, cremetory or other place): Washington National Cemetery
Dete: 1/17/2001
20c. Location - City or Town, Stete: Suitland, MD

21. Signature of Funerel Service Licensee: Joyce Montgomery-Cheatham
22. Name and Address of Facility: CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode ot dying, such as cardiac or respiretory arrest, shock, or heert tailure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in deeth) a.	RESPIRATORY FAILURE	2 WKS
Due to (or as a consequenca ot): b.	ANOXIC ENCEPHALOPATHY	2 WKS
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or es a consequence of): c.	VENTRICULAR FIBRILLATION / CARDIAC ARREST	2 WKS
Due to (or es a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION, DIABETES MELLITUS, PRIOR STROKE, ATRIAL FIBRILLATION, DEEP VEIN THROMBOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place ot Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 8☐ Othar (Specify)

27. Menner ot Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date ot Injury (Month, Dey Year)
28b. Time ot Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best ot my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, dete and placa, and due to the cause(s) and manner steted.

29b. Signature and title ot certifier: Steven T. Kariya
29c. License number: D36252
29d. Date signed (Month, Day, Year): JANUARY 16, 2001

30. Neme and address ot person who completed cause ot death (Item 23a) (Type, Print): STEVEN T. KARIYA, MD 11501 GEORGIA AVE. STE. 515 WHEATON MD 20902

State Registrar

31. Dete filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

6

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02828

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Marie Marion Jameson

2. Dete of Deeth — Month: JANUARY Dey: 04 Year: 2001

3. Time of Death: 11:50AM

4e Facility Neme *(If not institution, give street end number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-26-9112

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 77 Yrs.

If Under 1 Year — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Day, Year)*: January 31, 1923

9. Birthplace *(Stete or Foreign Country)*: New Foundland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: California

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 44049 Fieldstone Way

10f. Zip Code: 20619

10g. Citizen of Whet Country?: U.S.A.

11. Marital Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12th College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Store Clerk

16b. Kind of Business/Industry: Retail Store

17. Father's Neme *(First, Middle, Last)*: Stanley Sullivan

18. Mother's Neme *(First, Middle, Maiden Surname)*: Theresa Williams

19e. Inlorment's Neme/Reletionship *(Type, Print)*: Karen L. White (Daughter)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 44680 Clarke's Landing Road, Hollywood, Maryland 20636

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Immaculate Heart of Mary Cemetery

Dete: 1/8/01

20c. Location - City or Town, State: Lexington Park, Maryland

21. Signeture of Funerel Service Licensee: Michael Kevin Gardiner Jr.

22. Neme end Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)

a. Acute Respiratory Arrest — 30 minutes

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest

b. Acute exac of COPD/asthma

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Abdominal Aortic Aneurysm

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end plece, and due to the cause(s) and menner stated.

29b. Signeture and title of certifier: Konrad

29c. License number: D36206

29d. Dete signed *(Month, Day, Year)*: 01/6/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): DR. KIRAN MEHTA HOLLYWOOD, MD. 20636

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 08 2001

32. Registrer's Signeture: Donna B. Foster

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NMAE; MARIE MARIAN JAMESON

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02829

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: IDA MAE JOHNSON
2. Date of Death Month / Day / Year: JANUARY 20 2001
3. Time of Death: 6:38 PM
4e. Facility Neme *(If not institution, give street and number)*: 8215 MAPLEVILLE ROAD
4b. City, Town, or Location of Death: BOONSBORO
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 219-18-3162
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 12, 1914
9. Birthplace *(State or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10a. Stete: MARYLAND
10b. County: WASHINGTON
10c. City, Town or Location: BOONSBORO
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8215 MAPLEVILLE ROAD
10f. Zip Code: 21713
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER
16b. Kind of Business/Industry: PUBLIC SCHOOLS

17. Father's Name *(First, Middle, Last)*: WILLIAM MASON SHIPE
18. Mother's Name *(First, Middle, Meiden Surname)*: LISSA ETHEL WOMELDORFF

19e. Informent's Neme/Reletionship *(Type, Print)*: M. CAROL PEARSON/NIECE
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8215 MAPLEVILLE ROAD, BOONSBORO, MARYLAND 21713

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LORRAINE PARK CEMETERY
Date: 1/24/01
20c. Location - City or Town, State: WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee: Paul M. Dean
22. Name and Address of Facility: BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in deeth)
a. lung cancer — 9months

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Hind Hamdan MD
29c. License number: D46473
29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): Hind Hamdan, MD; 363 S. Cleveland Ave; Hagerstown, MD 21740

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 23 2001
32. Registrer's Signeture: D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02830

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Clayton Jones
2. Date of Death (Month, Day, Year): January 7, 2001
3. Time of Death: 9:55am
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 192-32-7353
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 8, 1941
9. Birthplace (State or Foreign Country): Franklin, Pa

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Takoma Park
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 402 Tulip Ave
10f. Zip Code: 20912
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 1 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Engineer
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Howard William Jones
18. Mother's Name (First, Middle, Maiden Surname): Thetis Annabelle Hall

19a. Informant's Name/Relationship (Type, Print): Cherly Jones /Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 Tulip Ave, Takoma Park, MD 20912

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 1-12-01
20c. Location - City or Town, State: Beltsville, md

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Alexander s. Pope Funeral HOme, 11315 Lockwood Drive, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SUBARACHNOID HEMORRHAGE — 48 H

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given In Part I.

UNSTABLE ANGINA PECTORIS
CAROTID ARTERY STENOSIS

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at tha time, date and place, end due to the ceuse(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or Investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ Ernesto Africano MD
29c. License number: D-19400
29d. Dete signed (Month, Day, Year): 1-8-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERNESTO AFRICANO, M.D., 344 UNIVERSITY BLVD #211, SILVER SPRING, MD.

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02831

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): STANLEY LEE JONES
2. Date of Death Month Day Year: Jan. 13, 2001
3. Time of Death: 6:10 pm
4a. Facility Name (If not institution, give street and number): Doctor's Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-74-0710
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 47 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 9, 1953
9. Birthplace (State or Foreign Country): Petersburg, VA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Landover
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 8948 Continental Place
10f. Zip Code: 20785
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postal Worker
16b. Kind of Business/Industry: Federal Government
17. Father's Name (First, Middle, Last): Stanley L. Jones
18. Mother's Name (First, Middle, Maiden Surname): Ada P. Mason
19a. Informant's Name/Relationship (Type, Print): Ada P. Jones/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 505 Suffolk Ave. #408 Capitol Heights, MD. 20743
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory
Date: 1/20/01
20c. Location - City or Town, State: Beltsville, MD.
21. Signature of Funeral Service Licensee: Ava J. Mikell
22. Name and Address of Facility: Pope Funeral Homes, 5538 Marlboro Pike Forestville, MD. 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Plasma Cell Leukemia

Due to (or as a consequence of):
b. Septic Shock

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Acute on Chronic Renal Failure

Due to (or as a consequence of):
d. Cardiorespiratory Arrest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Probable Blast Crisis
Severe Anemia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Felipe C. Robinson MD
29c. License number: D 29205
29d. Date signed (Month, Day, Year): 1/14/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FELIPE C. ROBINSON, M.D. 4987 BATTERY LN. BETHESDA, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: Penny D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02832

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John Michael Jenkins
2. Date of Death Month / Day / Year: January 6, 2001
3. Time of Death: 10:45 AM
4a. Facility Name *(If not institution, give street and number)*: 6038 Westchester Park Drive
4b. City, Town, or Location of Death: College Park
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215 66 9282
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 45 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 30, 1955
9. Birthplace *(State or Foreign Country)*: Washington D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 6038 Westchester Park Drive
10f. Zip Code: 20740
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter
16b. Kind of Business/Industry: American University

17. Father's Name *(First, Middle, Last)*: John Joseph Jenkins
18. Mother's Name *(First, Middle, Maiden Surname)*: Nina Payne

19a. Informant's Name/Relationship *(Type, Print)*: Nina P. Jenkins Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7014 Freeport St. Hyattsville Maryland 20784

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lakemont Memorial Gardens — Date: Jan. 9, 2001
20c. Location - City or Town, State: Davidsonville MD

21. Signature of Funeral Service Licensee: ▶ Robert E. Evans
22. Name and Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiopulmonary Arrest	5 min.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Recurrent Laryngeal Cancer	6 months
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)* / 28b. Time of Injury / 28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: 19101
29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bruce Davidson, MD 3800 Reservoir Road N.W. Wash. DC. 20007

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02833

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Albert Jones
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 3:34 PM
4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 402-990-071
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 11, 1945
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 9800 Cherry Hill Road
10f. Zip Code: 20740
10g. Citizen of What Country?: Canada

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: private

17. Father's Name (First, Middle, Last): Harold Jones
18. Mother's Name (First, Middle, Maiden Surname): Rose Boucher

19a. Informant's Name/Relationship (Type, Print): Marilyn E. Jones - wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9800 Cherry Hill Road College Park, Maryland 20740

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ward Funeral Home
Date: Jan. 15, 2001
20c. Location - City or Town, State: Toronto, Canada

21. Signature of Funeral Service Licensee: ▶ Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill RD. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction
Due to (or as a consequence of):
b. Diabetes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Berard, MD
29c. License number: D26287
29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Berard 7305 Baltimore Ave 107 College Park MD 20740

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: pending ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02834

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Johnston
2. Date of Death (Month, Day, Year): Jan. 21, 2001
3. Time of Death: 5:15 am
4a. Facility Name (If not institution, give street and number): 7396 Patrick Road
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 422-17-8061
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 24, 1911
9. Birthplace (State or Foreign Country): Ireland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7396 Patrick Road
10f. Zip Code: 21601
10g. Citizen of What Country?: Britain

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Textile Worker
16b. Kind of Business/Industry: Textile Manufacturing

17. Father's Name (First, Middle, Last): Robert McCune
18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Carlisle

19a. Informant's Name/Relationship (Type, Print): Mervyn Johnston - Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7396 Patrick Rd., Easton, MD 21601

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cambridge Crematory
Date: 1-22-01
20c. Location - City or Town, State: Cambridge, MD

21. Signature of Funeral Service Licensee: Joseph Conrad-Bromwell
22. Name and Address of Facility: Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613

Physician /Medical Examiner

22a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONIA	1/7/01
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ADVANCED DEMENTIA, MYELOPROLIFERATIVE DISORDER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: C.W. Bain MD
29c. License number: D0000250
29d. Date signed (Month, Day, Year): 1/22/01
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CALLUM BAIN, 609 DUTCHMANS LANE, EASTON, MD, 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02835

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SAMUEL ALLEN KIRBY SR.
2. Date of Death: Month January Day 12 Year 2001
3. Time of Death: 10:00PM
4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 225-52-7012
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 59 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 28 1941
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4697 Gadwell Place
10f. Zip Code: 20603
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter
16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Early Fonza
18. Mother's Name (First, Middle, Maiden Surname): Jennie Lynn Mawyer

19a. Informant's Name/Relationship (Type, Print): Samuel A. Kirby Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2902 Monroe Place, Falls Church, VA 22042

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Memorial Park
Date: 1/18/01
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Samuel A. Kirby
22. Name and Address of Facility: Murphy Falls Church Funeral Home 1102 W. Broad St., Falls Church, VA 22046

To Be Completed by Funeral Director

Samuel A. Kirby
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. LUNG CANCER
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
PANCYTOPENIA
ATHEROSCLEROTIC HEART DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-44436
29d. Date signed (Month, Day, Year): JAN 12 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ashvinkumar J. Patel,M.D. P.O. Box 1620 Waldorf,Maryland 20604

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02836

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KAY FRANCIS KNIGHT

2. Date of Death: Month JANUARY Day 17 Year 2001

3. Time of Death: 2050

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-26-3530

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 3, 1938

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: FRUITLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 508 SHELDON AVE.

10f. Zip Code: 21826

10g. Citizen of What Country?: U.S.A.

11. Maritel Stetus: 1☐ Nevar Marriad 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): CHARLES SMITH

18. Mother's Neme (First, Middle, Meiden Surneme): KATHERINE VOGELZAG

19a. Informent's Neme/Reletionship (Type, Print): CHARLES C. KNIGHT - HUSBAND

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 508 SHELDON AVE. FRUITLAND, MD 21826

20a. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or othar place): CAMBRIDGE CREMATORY | Dete: 1/20/01

20c. Location - City or Town, Stete: CAMBRIDGE, MARYLAND

21. Signeture of Funerel Service Licensee: Robert W. Harris Jr.

22. Neme end Address of Fecility: BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximete Interval Between Onset end Deeth

Immediete Causa (Finel disease or condition resulting in death)

a. Congestive Cardiomyopathy

Due to (or as a consequence of): AFIB

Sequentielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b.

Due to (or es a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- ESRD - HD
- HTN
-

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et tha time, date and place, end due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On tha basis of exeminetion and/or investigetion, in my opinion, death occurred at tha time, date end place, end due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Neurology

29c. License number: D-53611

29d. Data signed (Month, Day, Year): 1/18/01.

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): KAZI KHAN 547-G Riverside Dr, Salisbury, MD 21801.

State Registrar

31. Data filed (Month, Day, Year): JAN 19 2001

32. Registrer's Signeture: Jennie B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

KAY KNIGHT SS# 219-26-3530 1.17.01 2050 64yo

DQ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02837

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Angelina B. Kosif

2. Date of Death (Month, Day, Year): January 16, 2001

3. Time of Death: 10:22 am

4a. Facility Name (If not institution, give street and number): Union Memorial Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-90-2774

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 24 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 29, 1976

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4406 LaPlata Avenue, Apt A

10f. Zip Code: 21211

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Unemployed

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): John Salamone

18. Mother's Name (First, Middle, Maiden Surname): Brenda Wirth

19a. Informant's Name/Relationship (Type, Print): Necati Kosif (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4406 LaPlata Avenue, Apt A, Baltimore, Md. 21211

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Most Holy Redeemer

Date: 1/23/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Mabel T. Zeke

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. cardiomyopathy — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. endocarditis — 6 months

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ K. Wilson MD

29c. License number: AT 24389 46 A9

29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kathleen Wilson 201 East University Parkway Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02838

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John J. Kolar, Sr.

2. Date of Death — Month: January; Day: 20; Year: 2001

3. Time of Death: 0400

4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital of Baltimore

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-01-0063

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: April 26, 1913

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5003 Remmell Ave.

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant

16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: Frank Kolar

18. Mother's Name *(First, Middle, Maiden Surname)*: Antoinette Kriz

19a. Informant's Name/Relationship *(Type, Print)*: Mr. John J. Kolar, Jr. (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5003 Remmell Avenue, Baltimore, MD 21206

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oak Lawn Cemetery

Date: 1/24/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A. Miller

22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic shock — 2 days

Due to (or as a consequence of):
b. Pneumonia — 3 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)* 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ B. Acosta MD

29c. License number: RES000

29d. Date signed *(Month, Day, Year)*: January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): B. Acosta M.D. Sinai Hospital of Baltimore, 2401 West Belvedere Ave. Baltimore, M.D. 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: ▶ [signature]

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

John Kolar

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DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02839

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virginia Mae Krafthofer
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 4:15 am
4a. Facility Name *(If not institution, give street and number)*: National Lutheran Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-14-2464
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar 20, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 814 Orange Drive
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: William T. Wilson
18. Mother's Name *(First, Middle, Maiden Surname)*: Nettie V. Willard

19a. Informant's Name/Relationship *(Type, Print)*: George F. Krafthofer / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 814 Orange Drive, Silver Spring, MD 20901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery — Date: Jan 16 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Eric L Scerbo
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Alzheimer's Dementia	5 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: multi infarct dimentia, unstable colon Syndrom

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C Schemm M.D
29c. License number: D36618
29d. Date signed *(Month, Day, Year)*: January 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christopher Schemm, MD 9701 Viers Road, Rockville, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02840

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Edna Patricia Kolpack
2. Data of Death Month Day Year: January 12, 2001
3. Time of Death: 7:30 a.m.
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-32-4337
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: March 17, 1925
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: College Park
10d. Inside City Limits: 1☐ Yes 2☐ No
10e. Street and Number: 7528 Sweetbriar Drive
10f. Zip Code: 20740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry L. Clark
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie M. Ebert

19a. Informant's Name/Relationship *(Type, Print)*: Deborah Kadjeski - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 811 Richardson Drive, Harwood, Maryland 20776

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery
Date: 01/16/01
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic Cancer — 3 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32036
29d. Data signed *(Month, Day, Year)*: 1/14/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary J Sprouse 2108 Dibank Drive Chester, MD 21619

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

CPS
01-0071-037
JAMES KENNY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02841

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Russell Kenny, Jr.
2. Date of Death Month: January Day: 4 Year: 2001
3. Time of Death: 19:40
4a. Facility Name (If not institution, give street and number): 21265 Mayfaire Lane Apartment #101
4b. City, Town, or Location of Death: Great Mills
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 253-92-5559
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 49 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): December 26, 1951
9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Great Mills
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 21265 Mayfaire Lane Apt. 101
10f. Zip Code: 20634
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Navy
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Training Systems Manager
16b. Kind of Business/Industry: U.S. Navy

17. Father's Name (First, Middle, Last): James Russell Kenny, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Marjorie Louise DePratt

19a. Informant's Name/Relationship (Type, Print): Shannon M, Kenny (SIster)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8707 Foley Drive, Orlando, FL 32825

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 1/11/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael Kevin Hardin
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Cataract Gunshot of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year): 1/4/01
28b. Time of Injury: 1710 HR
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 21265 Mayfaire Lane Great Mills Maryland

29a. Certifier (Check only one) 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore M. King MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): January 5, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001
32. Registrar's Signature: D. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

10

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#5 perFHG794 4/4/2001 EW

Certificate of Death

Reg. No. 2001 02842

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ella May KEEDY

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 0932

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: ~~705-10-4602~~ 213-62-8244

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 11, 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1747-2 Edgewood Hills Circle

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): housewife

16b. Kind of Business/Industry: her home

17. Father's Name (First, Middle, Last): James Luther Bennett

18. Mother's Name (First, Middle, Maiden Sumame): Annie E. Grubbs

19a. Informant's Neme/Relationship (Type, Print): Charles E. Keedy - son

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1747-2 Edgewood Hills Circle, Hagerstown, Md 21740

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piace of Disposition (Neme of cemetery, cremetory or other piece): Rest Haven Cemetery

Date: 1-19-01

20c. Location - City or Town, Stete: Hagerstown, MD

21. Signature of Funeral Service Licensee: Scott Minnich

22. Name end Address of Fecility: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute myocardial infarction

Due to (or as a consequence of):

b. Sepsis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Due to (or es e consequence of):

c. Pneumonia

Due to (or as e consequenca of):

d. Congestive heart failure

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Hypertension

Hyperlipidemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and piace, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: [signature] M.D.

29c. License number: D0041131

29d. Date signed (Month, Day, Year): Jan. 18, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): GEORGE L. CORTELIS M.D. 338 Mill St. Hagerstown, MD 21740

State Registrar

31. Date filed (Month, Dey, Year): JAN 23 2001

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Keedy, Ella Mae

DHMH 16 Rev 6/95

ORIGINAL

JAN 2 : 1991

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend # 10c. Per FH PGC 1-16-01 cr

Certificate of Death

Reg. No. 2001 02843

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Gwendolyn Laverne Kelly	January 08 2001	8:10 am

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Onley	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Deta of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
245-86-5111	1☐ M 2☒ F	50 Yrs.			June 19, 1950	North Carolina

Usual Rasidance of Decedent

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
D.C.		Washington, ~~DC~~	1☒ Yas 2☐ No

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
723 Rittenhouse Street NW	20011	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorcad	1☐ Yas 2☒ No If Yas, Giva Year or Dates:	1☐ Yas 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highast grada complatad)		18a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
12th		Clerical	Private

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maidan Surname)
James McCoy	Maggie Knight

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)
Chanietta Kelly / Daughter	723 Rittenhouse Street NW Washington, DC 20011

20a. Mathod of Disposition	20b. Placa of Disposition (Nama of cematary, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)	Ressurection Cemetery	1-13-01	Clinton, Maryland

21. Signature of Funaral Sarvice Licensee: Kimberly Chesca-Towe

22. Nama and Addrass of Facility: Marshall's Funeral HOme 4308 Suitland Road Suitland Maryland 20746

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not antar the moda of dying, such es cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Intarval Batween Onset and Death
Immediata Causa (Final disaasa or condition rasulting in daath) a.	Respiratory Failure	2 weeks
Dua to (or as a consaquence of): b.	Multiple sclerosis	10 years
Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last — Dua to (or as a consaquanca of): c.	Aspiration Pneumonia	2 weeks
Due to (or as a consequence of): d.	Cerebral Vascular Accident	2 years

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
1☐ Yas 2☒ No	1☐ Yes 2☒ No

25. Was casa rafarrad to medical examiner?	28. Placa of Daath (Check only ona)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Othar: 4☐ Nursing Home 5☐ Residance 6☐ Othar (Specify)

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined		M	1☐ Yas 2☐ No	
	28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify)			28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
[signature]	D51908	January 8 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): David B. Magliaro MD 18111 Prince Phillip Drive Olney Maryland

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signatura
JAN 16 2001	[signature] G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02844

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Annie Kent

2. Date of Death (Month, Day, Year): January 9, 2001

3. Time of Death: 10:53 PM

4a. Facility Name (If not institution, give street and number): Casey House

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-38-8564

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 24, 1923

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9801 Cherry Tree Lane

10f. Zip Code: 20910

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Record Center Documentation

16b. Kind of Business/Industry: Pentagon Federal Gov't.

17. Father's Name (First, Middle, Last): Arthur Reid

18. Mother's Name (First, Middle, Maiden Surname): Mary Nancy Robinson

19a. Informant's Name/Relationship (Type, Print): Geraldine Murray / Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3455 Regency Paryway, Forrestville, Maryland 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 01/16/01

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Pancreatic cancer — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D35635

29d. Date signed (Month, Day, Year): January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan, M.D. 18111 Prince Philip Drive, Olney, Maryland 20832

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

Registrar's Signature: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 15, P.G. GC, 1/19/10

Certificate of Death

Reg. No. 2001 02845

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JoAnn Kathryn Knight
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 8:15PM
4a. Facility Name (If not institution, give street and number): 1 Arthur Drive East
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 192-34-9378
6. Sex: 1☐ M 2☒ F XX
7. Age (In yrs. last birthday): 56 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 11,1944
9. Birthplace (State or Foreign Country): Erie, PA.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Fort Washington
10d. Inside City Limits: 1☐ Yes 2☒ No X
10e. Street and Number: 1 Arthur Drive East
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No XX — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No XX Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use Retired): Assurance Engineer Computer Scientist Quality
16b. Kind of Business/Industry: Digex

17. Father's Name (First, Middle, Last): Clifford J. Knight
18. Mother's Name (First, Middle, Maiden Surname): Genevieve Meier

19a. Informant's Name/Relationship (Type, Print): Genevieve C. Knight/Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7970 Kane Road Transfer, PA. 16154

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory — Date: 1/13/2001
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ Geo. P. Kalas
22. Name and Address of Facility: George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd. Oxon hill, Md. 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute renal failure
Due to (or as a consequence of):
b. intestinal obstruction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. endometrial Cancer, metastatic
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Deidra Varner, MD
29c. License number: D33512
29d. Date signed (Month, Day, Year): 1/13/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DEIDRA L. VARNER, MD; 11701 Livingston Rd, #101; Ft. Washington, Md 20744

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Geraldine B. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

20

DHMH 16 Rev 6/95

EVELYN KITAHARA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02846

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn Toshiye Kitahara
2. Date of Death Month Day Year: January 12, 2001
3. Time of Death: 8:10 PM
4a Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 276-26-3115
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 22, 1918
9. Birthplace *(State or Foreign Country)*: California

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10370 Derby Drive
10f. Zip Code: 20723
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Asian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Kunijiro Date
18. Mother's Name *(First, Middle, Maiden Surname)*: Riku Kanazawa

19a. Informant's Name/Relationship *(Type, Print)*: David J. Kitahara / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10370 Derby Drive, Laurel, Maryland 20723

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory | Date: 01/15/01
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: James D. Schwartz
22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. OVARIAN CARCINOMA — ~1 YEAR

Due to (or as a consequence of):
b. CARDIORESPIRATORY ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner steted.

29b. Signature end title of certifier: Isabella Martire
29c. License number: D45014
29d. Date signed *(Month, Day, Year)*: JANUARY 13 / 2001

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): ISABELLA MARTIRE MD 8379 CHERRY LANE LAUREL MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: Geneva G. Sparks

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

ORIGINAL

RKD

01-0298-033

HO

CHIN KWON

2/5/01 yf amend item 23a,27,28a,b,c,d,e,f per me G792

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02847

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Data of Death Month	Dey	Yeer	3. Time of Death
Ho	C.	Kwon	JANUARY	18,	2001	12:05P.M.

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
POTOMAC RIVER	POTOMAC	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex 1☐M 2☐F	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-92-6250	XX	38 Yrs.					Nov. 11 1962	S. Korea

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits 1☐Yes 2☐No
Maryland	Prince Georges	Cheverly	XX

10e. Street and Number	10f. Zip Coda	10g. Citizen of What Country?
2901 Woodway Pl.	20785	U.S.A.

11. Maritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rsce - Amerlcan Indian, Bleck, White, etc.
1☐Never Married 2☐Merried 3☐Widowed 4☒Divorced	1☐Yes 3☒No If Yes, Give Yaar or Dates: XX	1☐Yes XX No Specify:	Specify: Korean

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Businass/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12	2	Secretary	AARP

17. Father's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)
Han Kwon	Hei Cha Chung

19e. Informent's Neme/Reletionship (Type, Print)	19b. Msiting Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Han Kwon (Father)	2901 Woodway Pl. Cheverly, MD 20785

20a. Method of Disposition 1☒Burial 2☐Cremetion 3☐Removel from Steta 4☐Donation 5☐Other (Specify)	20b. Plece of Disposition (Neme of cemetery, crematory or other piece)	Date	20c. Location - City or Town, Stete
X	Lakemont Memo. Gardens	1/24/01	Davidsonville, MD

21. Signature of Funeral Service Licensee	22. Nama and Address of Feciility
▶ Richard Rendon	Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter the moda of dying, such as cardiac or raspiratory errest, shock, or heart failure. List only one cause on each line.

		Approximate Intervsl Between Onset snd Desth
Immediate Cause (Finel diseese or condition resulting in deeth)	s. DROWNING	
	Due to (or as a consequence of):	
Sequentially list conditions, if sny, leeding to immedlete cause. Enter Underlying Csuse (Disease or Injury thet initieted events rasulting in deeth) Lsst	b.	
	Due to (or es e consequenca of):	
	c.	
	Dua to (or as a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown	
24s. Wes sn autopsy performed? 1☒Yes 2☐No	24b. Were sutopsy findings avsileble prior to completion of cause of desth? 1☒Yes 2☐No

25. Wes case referred to medical examiner? 1☒Yes 2☐No	26. Place of Deeth (Check only one) Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other (Specify) SCENE

27. Menner of Death 1☐Neturst 2☐Accident 3☒Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined	28a. Date of Injury (Month, Day Year) found 1/18/01	28b. Time of Injury found at noon M	28c. Injury at Work? 1☐Yes 2☒No	28d. Describe how injury occurred subject jumped from bridge into water
	28e. Plece of Injury - At home, ferm, street, fsctory, office building, etc. (Specify) water			28f. Location (Street end Number or Rural Route Number, City or Town, State) found on Potomac River Shore Oxon Hill, Md

29e. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dste end plece, end due to the csuse(s) snd manner ss ststed.
2☒ **Medicel Examiner:** On the basis of exemlnetion and/or investigstion, in my opinion, deeth occurred st the time, dete end place, and due to the csuse(s) and menner steted.

29b. Signetura and title of certifier	29c. License number	29d. Data signad (Month, Dey, Year)
▶ Light L Marks, M.D.	O.C.M.E.	JANUARY 19, 2001

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)
Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dste filed (Month, Dey, Year)	32. Registrer's Signeture
JAN 23 2001	▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02848

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Data of Death (Month, Day, Year)	3. Time of Death
EVELYN	KANDEL	JAN. 15, 2001	8:08A.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Hebrew Home of Greater Washington	Rockville	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
577-14-7598	1☐ M 2☒ F	93 Yrs.			July14,1907	England

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Bethesda	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7401 Westlake Terrace, #809	20817	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yaar or Datas:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
12		Housewife	own home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Morris Rosenberg	Sarah Beider

19a. Interment's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Arnold Kandel - son	11420 Strand Drive, #407 Rockville, Maryland 20852

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	King David Memorial Garden	1/17/2001	Falls Church, VA

21. Signature of Funeral Service Licensee: Donald V. Borgwardt

22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onsat and Death
Immediate Cause (Final disaase or condition resulting in death)	a. Pneumonia	3days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Dua to (or as a consequence ot):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pancreatic Carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Piece ot Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
Gregory A Compton MD	D24942	JAN 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 19 2001	G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02849

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Jacob H. Kress
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 5:15A.
4a. Facility Name *(If not institution, give street and number)*: 8908 Maxwell Drive
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 237-32-7519
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 92 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 13, 1908
9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Florida
10b. County: Alachua
10c. City, Town or Location: Gainesville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2615 Northwest 22nd Drive
10f. Zip Code: 32605
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 8
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Doctor
16b. Kind of Business/Industry: Medicine

17. Father's Name *(First, Middle, Last)*: Leon Kress
18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Cohen

19a. Informant's Name/Relationship *(Type, Print)*: Miriam Avrunin - Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8908 Maxwell Drive Potomac, Maryland 20854

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: B'nai Israel Cemetery
Date: 1/18/2001
20c. Location - City or Town, State: High Point, North Carolina

21. Signature of Funeral Service Licensee: Donald V Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the *mode* of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Non Hodgkins Lymphoma — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Daughters home

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Kaplan MD
29c. License number: D35635
29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph Kaplan, M.D. 18111 Prince Philip Drive, #327 Olney, Maryland 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001 pending
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02850

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pattie S. Kaylor
2. Date of Death (Month, Day, Year): Jan. 9, 2001
3. Time of Death: 1:30p.m.
4a. Facility Name (If not institution, give street and number): Manor Care potomac
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 229-28-9826
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 19, 1919
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: D.C.
10b. County:
10c. City, Town or Location: Washington, D.C.
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4201 Butterworth Place NW #432
10f. Zip Code: 20016
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 2+ College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Staff/Secretary
16b. Kind of Business/Industry: American Red Cross WWII

17. Father's Name (First, Middle, Last): Ormonde Smith, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Katherine Saunders

19a. Informant's Name/Relationship (Type, Print): Patrick Smith Nephew
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 655 Colonial View Rd, Mechanicsburg, PA 17055

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Crematory
Date: 01/18/
20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: National Funeral Home 7482 Lee Highway, Falls Church, VA 22042

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CVA — 2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Michael J Grady
29c. License number: MD0038781
29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael J. Grady, M.D. 4910 Massachusetts Ave. NW #210, Washington DC 20016

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

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Medical Certification: To Be Completed by Physician/Medical Examiner

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Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02851

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irene Long

2. Date of Death — Month: Jan. Day: 18 Year: 2001

3. Time of Death: 1:30P.M.

4a. Facility Name (If not institution, give street and number): Ridgeway Nursing Home

4b. City, Town, or Location of Death: Catonsville

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 178-05-3393

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 29, 1910

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3125 Pelham Avenue

10f. Zip Code: 21213

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Grocery

17. Father's Name (First, Middle, Last): William Franklin Bowman

18. Mother's Name (First, Middle, Maiden Surname): Gertrude Emma Yost

19a. Informant's Name/Relationship (Type, Print): Mrs. Diane Wilhelm (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9270 W. Stayman Dr., Ellicott City, Md. 21042

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Odd Fellows Cemetery

Date: 1/22/01

20c. Location - City or Town, State: Shamokin, Pennsylvania

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Breast Carcinoma. — less than one year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Coronary Vascular Disease

Hypothyroid

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael Schwartz

29c. License number: D19667

29d. Data signed (Month, Day, Year): 01-18-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Schwartz, M. D., Ridgeway Manor Nursing Home, 5743 Edmondson Ave., Catonsville. Md. 21228

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Bl

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02852

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Matilda Amelda Languis

2. Date of Death: Month Jan. Day 17 Year 2001

3. Time of Death: 1745

4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-07-3015

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 04/10/1917

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 715 Juniata Street

10f. Zip Code: 21078

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Self Employed

16b. Kind of Business/Industry: Grocery Store

17. Father's Name (First, Middle, Last): Cherubino Toti

18. Mother's Name (First, Middle, Maiden Surname): Felicia Marzelli

19a. Informant's Name/Relationship (Type, Print): Maria Jones- Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 715 Juniata St., Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Erin Cemetery

Date: 1/20/01

20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: Dykaire M. Smith

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. MESENTERIC ISCHEMIA

Due to (or as a consequence of):

c. GANGRENE OF BOWEL (SMALL)

Due to (or as a consequence of):

d. INTESTINAL OBSTRUCTION

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CORONARY INSUFFICIENCY

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

DIABETIS MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A.P. Canlas

29c. License number: D25597

29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A.P. CANLAS, M.D. 504 LEWIS ST. HAVRE DE GRACE, MD 21078

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Matilda Languis 1/17/01 1745 BH

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02853

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDITH C. LEONARD LETT

2. Date of Death: Month JANUARY Day 13 Year 2001

3. Time of Death: 4:30PM

4a. Facility Name (If not institution, give street and number): Citizens Nursing Home

4b. City, Town, or Location of Death: HavredeGrace

4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 203-24-8769

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6/23/1918

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Street

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3731 Bay Road

10f. Zip Code: 21154

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married ☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): David Franklin Barlow

18. Mother's Name (First, Middle, Maiden Surname): Lula L. McCloud

19a. Informant's Name/Relationship (Type, Print): Anna MArie Weaver-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3731 Bay Rd.,Street, MD 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Highview Mem. GArdens

Date: 1/17/2001

20c. Location - City or Town, State: Fallston,MD

21. Signature of Funeral Service Licensee: Jeffrey R. Hovelidge

22. Name and Address of Facility: Harkins F.H.Inc.,600 MAin St, Delta,PA 17314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. PNEumonIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- DIVERTICULITIS
- GASTROINTESTINAL BLEEDING

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T. Bondo MD

29c. License number: D42800

29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. Bondo MD 314 S. Union Ave Havre de Grace, Md 21078

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

LETT, Edith

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02854

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MELVIN STANLEY LORDEN
2. Date of Death: Month JAN Day 19 Year 2001
3. Time of Death: 15:58 HR
4a. Facility Name (If not institution, give street and number): ERUPPER CHESAPEAKE MED CTR
4b. City, Town, or Location of Death: BELAIR
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 220-20-4519
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 18, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Kingsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7016 Heathcoate Drive
10f. Zip Code: 21087
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Mechanic
16b. Kind of Business/Industry: Garage

17. Father's Name (First, Middle, Last): John Lorden
18. Mother's Name (First, Middle, Maiden Surname): Elsie Empkey

19a. Informant's Name/Relationship (Type, Print): Mrs. Anna M. Lorden (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7016 Heathcoate Drive, Kingsville, MD 21087

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sacred Heart of Jesus
Date: 1/23/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian A Weller
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DMG
29c. License number: OCME
29d. Date signed (Month, Day, Year): JAN 19, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GPRABHU MD 728 BELAIR RD BELAIR 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

6+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02855

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
LOIS	McMILLEN	LEUKEL	1	19	01	3:18 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Atlantic General Hospital	Berlin	Worcester

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
151-16-5430	1☐ M 2☒ F	84 Yrs.			11/13/1916	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD.	Worcester	Ocean City	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8906 Rusty Anchor Road #15	21843	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	School Teacher	Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Preston A. McMillen	Eva Pauline Lesh

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
George A. Leukel III/Son	P.O. Box 3796 Ocean City, Md. 21843

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Bethel Cemetery	1/24 2001	Madonna, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
M. Stocker Kurtz III	E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. pneumonia	5 days
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Physician	H44283	1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Burke, 9733 Healthcare Drive, Berlin, MD

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 23 2001	D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Leukel, Lois M. 151165430 11/13/16 - 1/19/01

BK

20

01-0167-041
B.K.S
UNKNOWN 01-009

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

HENRY DONALD LINDELL — *Certificate of Death* — Reg. No: 2001 02856

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: HENRY DONALD LINDELL
2. Dete of Death Month / Dey / Yeer: JAN. 10. 2001
3. Time of Death: 7:40 AM
4e Facility Neme *(If not institution, give street and number)*: 25134 WATCH GOOSE FARM ROAD
4b. City, Town, or Location of Deeth: ST.MICHAELS
4c. County of Deeth: TALBOT

Funeral Director

5. Sociel Security Number: 222-10-8764
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthdey)*: 78 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Jan. 11,1922
9. Birthplece *(Stete or Foreign Country)*: Washington D.C.

Usuel Residence of Decedent

10a. State: Maryland
10b. County: Talbot
10c. City, Town or Location: St. Michaels
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 25134 Watch Goose Farm Rd.
10f. Zip Code: 21663
10g. Citizen of What Country?: U.S.A.
11. Meritel Stetus: 1 [ ] Never Merried 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes: WWII Army Air Corps
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen Indian, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Sr. V.P.
16b. Kind of Business/Industry: Continental Insurance
17. Father's Neme *(First, Middle, Last)*: Sven Ivar Lindell
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Laura Freeman
19a. Informent's Neme/Reletionship *(Type, Print)*: Peggy E. Lindell Wife
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 25134 Watch Goose Farm Rd, St, Michaels, Md. 21663
20e. Method of Disposition: 1 [ ] Buriel 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Capitol Crematory
Dete: Jan. 16,2001
20c. Location - City or Town, Stete: Dover, Delaware
21. Signeture of Funerel Service Licensee: Harrison E. Leonard
22. Neme and Address of Facility: Harrison E. Leonard Funeral Home, 312 S. Talbot St. St. Michaels, Maryland 21663

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart feilure. List only one cause on eech line. — Approximete Intervel Between Onset end Death

Immediete Cause (Finel diseese or condition resulting in death): a. SMOKE INHALATION
Due to (or es e consequence of):
Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last:
b.
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

23b. Did tobecco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown
24a. Wes en eutopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [X] Yes 2 [ ] No
25. Wes cese referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* AT SCENE
27. Menner of Deeth: 1 [ ] Netural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*: 1/10/01
28b. Time of Injury: 0550 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SUBJECT WAS VICTIM OF HOUSE FIRE
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*: AT HOME
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*: 25134 WATCH GOOSE FARM RD, ST. MICHAELS, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) and menner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.
29b. Signeture and title of certifier: M.D.
29c. License number: O.C.M.E
29d. Dete signed *(Month, Day, Year)*: JAN. 11, 2001
30. Nems and eddress of person who completed cause of deeth (Item 23a) (Type, Print): Mary C. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 16 2001
32. Registrer's Signeture: Donna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036 — To Be Completed by Funeral Director — permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, — **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3bB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02857

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nicholas Ryan Lontos

2. Date of Death: Month JANUARY Day 20 Year 2001

3. Time of Death: 8:25 PM

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: N/A

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours 8 / Min. 4

8. Date of Birth *(Month, Day, Year)*: January 20, 2001

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: California

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 45930 Halsey Court

10f. Zip Code: 20619

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Infant

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Ryan Tom Lontos

18. Mother's Name *(First, Middle, Maiden Surname)*: Lori Jan Smith

19a. Informant's Name/Relationship *(Type, Print)*: Ryan T. Lontos (Father)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 45930 Halsey Court, California, Maryland 20619

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charles Memorial Gardens

Date: 1/23/01

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael L. Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Extreme prematurity (25 wks gestation)	8°
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypoplastic lungs	8°
Due to (or as a consequence of):		
	c. Multiple pneumothoraces	2°
Due to (or as a consequence of):		
	d. Pulmonary Interstitial Emphysema	4°

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD, FAAP Pediatrician

29c. License number: D50458

29d. Date signed *(Month, Day, Year)*: 1-21-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KEITH LINDERMAN M.D. 23140 MOAKLEY STREET SUITE 2 LEONARDTOWN, MD. 20650

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NICHOLAS RYAN LONTOS

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02858

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARIE LAWRENCE
2. Date of Death Month / Day / Year: January 19, 2001
3. Time of Death: 10:45PM
4a. Facility Name *(If not institution, give street and number)*: FutureCare Pineview
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 577-36-5602
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 3, 1922
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10203 Thrift Road
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic Worker
16b. Kind of Business/Industry: Private Homes

17. Father's Name *(First, Middle, Last)*: Hezekiah Greenwell
18. Mother's Name *(First, Middle, Maiden Surname)*: Corrina Johnson Gray Curtis

19a. Informant's Name/Relationship *(Type, Print)*: Edward G. Lawrence, Jr. (Son)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10203 Thrift Road, Clinton, Maryland 20735

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Marks UAME Cemetery
Date: 1/25/2001
20c. Location - City or Town, State: Valley Lee, Maryland

21. Signature of Funeral Service Licensee: Michael R Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
a. METASTATIC CARCINOMA — WEEKS
Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
b. Due to (or es a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D12906
29d. Date signed *(Month, Day, Year)*: 1/20/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis V. Kaufman, MD 12070 Old Line Centre, Waldorf, Maryland 20602

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 21 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

CPS
01-0312-011
WILLIAM LIDEN
AMENDED#1 per ME G793 031501 SS
AMENDED# 23& 27 per ME G793 031301 SS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02859

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ~~WILLIAM ELBERT LIDEN JR.~~ William Liden, Jr.

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 6:10 AM

4a. Facility Name (If not institution, give street and number): 609 Old Denton Road

4b. City, Town, or Location of Death: Federalsburg

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 214-34-7918

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1935

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: CAROLINE

10c. City, Town or Location: FEDERALSBURG

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 609 OLD DINTON ROAD

10f. Zip Code: 21632

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+): 7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TAX PREPARER

16b. Kind of Business/Industry: TAX PREPARER

17. Father's Name (First, Middle, Last): WILLIAM ELBERT LIDEN

18. Mother's Name (First, Middle, Maiden Surname): MARGARET COOK

19a. Informant's Name/Relationship (Type, Print): WM. EDWARD LYDEN / COUSIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 116 CHAMBERS ST. FEDERALSBURG, MD 21632

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bloomery Cemetery

Date: 01/24/01

20c. Location - City or Town, State: FEDERALSBURG MD.

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: WILLIAMSON FUNERAL HOME FEDERALSBURG, MD 21632

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. DILATED CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) SCENE

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated. 2 [X] **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Theodore M. King MD

29c. License number: o.c.m.e.

29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Theodore M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: ▶ Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02860

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Lytle

2. Date of Death (Month, Day, Year): January 10, 2001

3. Time of Death: 2355

4a. Facility Name (If not institution, give street and number): Prince Georges Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 224-36-1271

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 23, 1907

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: D.C.

10b. County: N?A

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10a. Street and Number: 303 Taylor Street N.W.

10f. Zip Code: 20011

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): – ; Coilege (1-4or 5+): –

16a. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired): Farmer

16b. Kind of Business/Industry: Agriculture

17. Father's Neme (First, Middle, Last): Clarence Knox

18. Mother's Neme (First, Middle, Maiden Sumeme): Vertie Johnston

19e. Informent's Neme/Reletionship (Type, Print): Keith L. Holt (Grandson)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 303 Taylor Street N.W. Washington, D.C. 20011

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Lee Crematory

Dete: Jan 13, 2001

20c. Location - City or Town, Stete: Clinton, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Fecility: Lee Funeral Home, INC 6633 Old Alexander Ferry Rd. Clinton, Md. 20735

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Deeth

Immedeite Ceuse (Finel diseese or condition resulting in deeth)

a. Cardiac Arrhthymia — Minutes

Due to (or es e consequence of):

Coronary Artery Disease — Years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No N?A

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner as steted. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signature end title of certifier: [signature]

29c. License number: D31069

29d. Dete signed (Month, Day, Year): 1-18-01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): George H. Bone, M.D. 1100 Mercantile Lane # 135 Largo, Maryland 20774

State Registrar

31. Dete filed (Month, Day, Year): JAN 19 2001 pending

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02861

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Katherine H. Mackenzie
2. Date of Death (Month, Day, Year): January 10 2001
3. Time of Death: 6:45AM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Rehabilitation and Nursing Center
4b. City, Town, or Location of Death: Burtonsville, MD
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-14-5101
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 1 1922
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4912-3 Columbia Road
10f. Zip Code: 21044
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use ratired)*: Bookkeeper
16b. Kind of Businass/Industry: Real Estate

17. Father's Name *(First, Middle, Last)*: Alexander Hagedorn
18. Mother's Name *(First, Middle, Meiden Surneme)*: Emma Johanna Peters

19a. Informant's Name/Relationship *(Type, Print)*: Mary McLaughlin/Daughter
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: 10704 New Hampshire Ave, Silver Sring, MD 20903

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Chesapeake Crematory Inc | Date: Jan. 12 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Stephen D Lohrmann
22. Name and Address of Facility: Rapp Funeral & Cremation Service, Stephen D. Lohrmann, 933 Gist Ave., Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on each lina.

		Approximata Intarval Batween Onset and Death
Immediata Causa (Final disease or condition resulting in death)	a. Emphysema	10 years
	Dua to (or as a consaquenca of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequenca of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa givan in Part I.: Type 2 diabetes mellitus; Congestive heart failure

23b. Did tobacco use contributa to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to compietion of cause of death? 1☐ Yes 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Homa 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul M
29c. License number: D43237
29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print): Dr. Paul Armstrong, 14201 Laurel Park Dr., #202, Laurel, MD 20707

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 17 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02862

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy R. Minnick

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 9:20 P.M.

4a. Facility Name (If not institution, give street and number): Stella Maris Hospice

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-03-1207

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 30, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4233 Nicholas Avenue

10f. Zip Code: 21206

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown — College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Charles Booz

18. Mother's Name (First, Middle, Maiden Surname): Sophia Wolf

19a. Informant's Name/Relationship (Type, Print): Mrs. Carol Schatz (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2204 Candice's Choice Ct., Apt E, Bel Air, Md. 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Lawn — Date: 1/22/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Brian D. Lewis

22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pyelonephritis Sepsis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertrophic Joint Disease, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Christopher Lewis

29c. License number: 055283

29d. Date signed (Month, Day, Year): 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1147 South Hanover Street Baltimore MD 21230

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Penny P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Amend item#28a,b,c,d,e,f,HCHD 1/18/01 BRH

Reg. No. 2001 02863

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDGAR EARL McFADDEN
2. Data of Death — Month: January; Day: 15; Year: 2001
3. Time of Death: 3:45AM
4a. Facility Name *(If not institution, give street and number)*: University of Maryland Medical Center
4b. City, Town, or Location of Death: Baltimore, MD
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 219-01-5778
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Dec. 24, 1920
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 415 Hillcrest Drive
10f. Zip Code: 21001
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yas, Giva Yaar or Datas: 1943-46
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12; Collega (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa retired)*: Manager
16b. Kind of Business/Industry: Plants
17. Father's Nama *(First, Middla, Last)*: Clarence McFadden
18. Mother's Nama *(First, Middle, Maiden Surnama)*: Anna Simmonds
19a. Informant's Neme/Ralationship *(Type, Print)*: Edgar E. McFadden, Jr. (Son)
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: 602 Millwood Dr. Fallston, Maryland 21047
20a. Mathod of Disposition: 1☒ Buriel 2☐ Crametion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Baker Cemetery
Data: 1/18/01
20c. Location - City or Town, Stata: Aberdeen, Maryland
21. Signature of Funeral Service Licensee: Kenneth B. Cargo
22. Neme and Addrass of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Causa (Final diseasa or condition resulting in death):
a. Intracerebral hemorrhage — 10 hours
Due to (or as a consequance of):

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaase or injury that initiated events rasulting in death) Last
b. Dua to (or as a consequanca of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.
atrial fibrillation
Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was en autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to complation of cause of death? 1☐ Yas 2☒ No
25. Was casa rafarred to medical examinar? 1☐ Yas 2☒ No
26. Placa of Deeth *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Data of Injury *(Month, Day Year)*
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☒ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, data and place, and due to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated.
29b. Signature and titla of certifiar: SURGICAL RESIDENT
29c. Licanse number: MD417643SA13161
29d. Data signed *(Month, Day, Year)*: January 15, 2001
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): EDWARD ANN, UMMS, 22 S. Greene St. Baltimore, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001
32. Registrar's Signature: Geneva B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

BN

6+1

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02864

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Jane Murk
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 6:35 PM
4a. Facility Name (If not institution, give street and number): 9539 Bauer Avenue
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-36-7294
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 21, 1938
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9539 Bauer Avenue
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Account Clerk
16b. Kind of Business/Industry: Utility Company

17. Father's Name (First, Middle, Last): Edward C. Murk
18. Mother's Name (First, Middle, Maiden Surname): Jane M. D'Alessandro

19a. Informant's Name/Relationship (Type, Print): Mrs. Venetia Hayden (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9861 N. Double Diamond Pl. Tucson, AZ 85742

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Green Mount Crematory
Date: 1/17/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Amanda Kelly
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):
b. ATHEROSCLEROSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. HYPERLIPIDEMIA

Due to (or as a consequence of):
d. DIABETES

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ JSchultz MD
29c. License number: D33728
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEFFREY SCHULTZ MD 8817 BELAIR RD #111 BALTIMORE MD 21236

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

BN

12

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 19a per F.D. 01/22/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02865

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Stephen McBeth

2. Date of Death Month: 01 Day: 21 Year: 01

3. Time of Death: 1000

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-58-1125

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 49 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 4 1952

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 326 First Street

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Systems Analyst

16b. Kind of Business/Industry: National Weather Service

17. Father's Name *(First, Middle, Last)*: Charles Hubert McBeth

18. Mother's Name *(First, Middle, Maiden Surname)*: Eleanor Sullanek

19a. Informant's Name, Address, and Relationship *(Type or Print)*: ~~Nancy Kountz/wife~~ Nancy McBeth Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 326 First Street Annapolis, MD

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Sfafa 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or othar piece)*: Kriders Cemetery

Date: 1/24/2001

20c. Location - City or Town, State: Westminster, MD

21. Signature of Funeral Service Licensee: John K Apple

22. Name and Address of Facility: Fritts Funeral Home and Chapel 412 Washington Road Westminster, MD21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Septic shock	2 days
Due to (or as a consequence of): b.	pneumonia	3 days
Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due fo (or as a consequence of): c.	advanced multiple sclerosis	
Due fo (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residanca 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accidenf 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner as stated. 2 ☐ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signatura and title of certifier: Berez MD

29c. License number: D0029571

29d. Date signed *(Month, Day, Year)*: 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul Berez MD 1655 Crofton Blvd suite 101 Crofton MD 21114

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 22 2001

32. Registrar's Signature: Geneva G Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02866

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julian Miller

2. Data of Daath (Month, Day, Yaar): January 12, 2001

3. Tima of Death: 2:20pm

4a. Facility Nama (If not institution, give street and number): WILLIAM HILL MANOR (#18 Shannon Terrace)

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 210-07-5586

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): OCT 24 1910

9. Birthplaca (State or Foraign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: [X] Yes 2 [ ] No

10e. Street and Number: #18 SHANNON TERRACE

10f. Zip Code: 21601

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yas 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ATTORNEY

16b. Kind of Business/Industry: LEGAL

17. Fathar's Name (First, Middle, Last): JOHN O. MILLER

18. Mother's Name (First, Middle, Maiden Surname): LUCY KENNEDY

19a. Informant's Name/Relationship (Type, Print): DAVID F. MILLER/ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 208 S. HANSON ST., EASTON, MD 21601

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): CHESAPEAKE CREMATION CTR | Date: 1-13-01

20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Servica Licansee: ▶ Joseph M. Ostrowski

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Brain Stem Cerebrovascular Accident — 3 hrs

Due to (or es e consequence of):

b. Cerebral Arteriosclerosis — 10 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive

23b. Did tobacco uaa contribute to the causa of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performad? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Home 5 [X] Residenca 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, straet, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of cartifiar: ▶ William H. Wood J MD

29c. License number: D08715

29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): WILLIAM H. WOOD, JR M.D. 505 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001

32. Registrar's Signature: ▶ Brenda G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rav 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #5 PER F.H. G792 2-6-02 WR.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02867

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL FOGLE MICKEY, SR.

2. Date of Death: Month JANUARY Day 18 Year 2001

3. Time of Death: 12:40 PM

4a. Facility Name (If not institution, give street and number): 7288 WAVERLY ISLAND RD

4b. City, Town, or Location of Death: EASTON

4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: ~~578-40-6135~~ ~~577-14-7011~~

6. Sex: 1 X M 2 ☐ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Data of Birth (Month, Day, Year): SEPT 3 1914

9. Birthplace (State or Foreign Country): NC

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1 ☐ Yes X ☐ No

10e. Street and Number: 7288 WAVERLY ISLAND RD

10f. Zip Code: 21601

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LAWYER

16b. Kind of Business/Industry: PRIVATE LAW

17. Father's Name (First, Middle, Last): EDWARD T. MICKEY

18. Mother's Name (First, Middle, Maiden Surneme): ADA FOGLE

19a. Informant's Name/Relationship (Type, Print): FRANK T. MICKEY/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 28534 CONGRESSIONAL COURT, EASTON, MD 21601

20a. Method of Disposition: 1 ☐ Burial 2 X Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other placa): CHESAPEAKE CREMATION CTR

Data: 1-19-01

20c. Location - City or Town, State: STEVENSVILLE, MD

21. Signature of Funeral Service Licensee: ▶ [signature] & CFSP

22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601

Physician /Medical Examiner

23a. Part1(Enter the disease, or complications that causad the daath. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia — 48hrs

Due to (or as a consequenca of):

b. Parkinsons Disease — 5yrs

Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last

Due to (or as a consequenca of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yas 2 X No

24b. Were autopsy findings available prior to complation of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examinar? 1 ☐ Yas 2 X No

26. Place of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 X Residenca 6 ☐ Other (Specify)

27. Manner of Deeth: 1 X Netural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) and manner steted.

29b. Signature and title of certifier: ▶ William H Wood Jr MD

29c. Licansa number: D0825

29d. Date signed (Month, Day, Year): 1/18/01

30. Nama and address of person who completed cause of death (Item 29a) (Type, Print): WILLIAM H. WOOD JR, M.D. 505 DUTCHMANS LANE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

PAUL F. MICKEY, SR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02868

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rosa Bell Murray
2. Date of Death (Month, Day, Year): January 21 2001
3. Time of Death: 1150
4a. Facility Name (If not institution, give street and number): Union Hospital
4b. City, Town, or Location of Death: Elkton
4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 214-76-5751
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 25 1928
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Cecil
10c. City, Town or Location: Elkton
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 1288 Pulaski Highway
10f. Zip Code: 21921
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6yrs; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): disabled
16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Lacy Cook
18. Mother's Name (First, Middle, Maiden Surname): Cleo Parks Cook

19a. Interment's Name/Relationship (Type, Print): Oma Graham/ sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15171 Drapers Mill Road Goldsboro, MD 21636

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greensboro Cemetery
Date: 01/26
20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: ▶ Fleegle (Fleegle)
22. Name and Address of Facility: FLeegle-Helfenbein Funeral Home, P.A. P.O. Box 160 Greensboro, MD 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Dilated Cardiomyopathy — >2years
Due to (or as a consequence of):
b. Ventricular Tachycardia — <1 month
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. Congestive Heart Failure — >2 years
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Morbid Retardation ; COPD , CVAs

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated.
29b. Signeture and title of certifier: ▶ Joseph K. Weidner Jr MD
29c. License number: D44373
29d. Date signed (Month, Day, Year): 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joseph K Weidner, Jr MD 101 Colonial Way Rising Sun, MD 21911

State Registrar

31. Date filed (Month, Day, Year): JAN 26 2001
32. Registrar's Signature: ▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02869

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Martin
2. Date of Death: Month: January Day: 9 Year: 2001
3. Time of Death: 1311
4a. Facility Name (If not institution, give street and number): University of Maryland
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 213-56-6287
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 24, 1950
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1313 Motter Avenue, #1
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Chester A. Selbu, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Nettie Bowie

19a. Informant's Name/Relationship (Type, Print): John R. Martin (Husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 9252, Silver Spring, MD 20960

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Ash Memorial Cem.
Date: 1/16/01
20c. Location - City or Town, State: Sandy Spring, MD

21. Signature of Funeral Service Licensee: George R. Snowden Sr.
22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Tension Pneumothorax
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Pulmonary Embolism
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day, Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Menaker MD
29c. License number: 13041
29d. Date signed (Month, Day, Year): January 9 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Menaker MD, 22 South Broome St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02870

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Philip Isidoro Mantua
2. Date of Death Month / Day / Year: January 16, 2001
3. Time of Death: 5:35 am
4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-52-0267
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 64 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 2, 1936
9. Birthplace *(State or Foreign Country)*: DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 3619 Dunnington Road
10f. Zip Code: 20705
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Barber
16b. Kind of Business/Industry: Hair

17. Father's Name *(First, Middle, Last)*: Isidoro Mantua
18. Mother's Name *(First, Middle, Maiden Surname)*: Bridget Maree

19a. Informant's Name/Relationship *(Type, Print)*: Dolores J. Mantua / Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3619 Dunnington Road, Beltsville, MD 20705

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: Jan 19 2001
20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: Scott L. Smith
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediete Cause (Finel disease or condition resulting in death)	a. hepatocellular carcinoma	6 weeks
	Due to (or es a consequence ot):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence ot):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: hepatic encephalopathy; cirrhosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner ot Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. 2 [ ] **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the ceuse(s) end menner steted.

29b. Signature end title of certifier: George A. Sotos MD
29c. License number: D43083
29d. Date signed *(Month, Day, Year)*: January 16, 2001

30. Name and address ot person who completed cause of deeth (Item 23a) (Type, Print): George A. Sotos, MD 9707 Medical Center Drive #300 Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

PHILIP MANTUA - 1/16/01 5:35AM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#12 per Phyg800 10/23/01EW

Certificate of Death

Reg. No. 2001 02871

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward J. Mescher

2. Date of Death: Month January Day ~~15~~ 12 Year 2001

3. Time of Death: 4:35 pm

4a. Facility Name (If not institution, give street and number): 10101 Gardiner Avenue

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 479-16-2382

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct 18, 1915

9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10101 Gardiner Avenue

10f. Zip Code: 20902

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor

16b. Kind of Business/Industry: Thompson's Dairy

17. Father's Name (First, Middle, Last): Frank Henry Mescher

18. Mother's Name (First, Middle, Maiden Surname): Henrietta Hatten

19a. Informant's Name/Relationship (Type, Print): Elizabeth J. Mescher / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10101 Gardiner Avenue, Silver Spring, MD 20902

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): St. John's Cemetery

Date: Jan 16 2001

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: ▶ Andrew J. Cole

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD

29c. License number: D 35162

29d. Date signed (Month, Day, Year): January 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Schindler, MD 10801 Lockwood Drive, Silver Spring, MD 20901

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: ▶ G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02872

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Owens Mattingly
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 6:00 am
4a. Facility Name (If not institution, give street and number): 38655 Collin Wood Road
4b. City, Town, or Location of Death: Abell
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 214-58-0945
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 90 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): September 9, 1910
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Abell
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 38655 Collin Wood Road
10f. Zip Code: 20606
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: At Home
17. Father's Name (First, Middle, Last): Benjamin I. Owens
18. Mother's Name (First, Middle, Maiden Surname): Lucy Rebecca Norris
19a. Informant's Name/Relationship (Type, Print): Col. James Donald Mattingly son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 38655 Collin Wood Road, Abell, Maryland 20606
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Joseph's Catholic Cemetery
Date: January 24, 2001
20c. Location - City or Town, State: Morganza, Maryland
21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A., 22955 Hollywood Road, P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cholangiocarcinoma — months

Due to (or as a consequence of):
b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Bone replacement
Coronary Artery Disease
Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David M. Federle
29c. License number: D34198
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David M. Federle 24035 Three Notch Road Hollywood, Md 20636

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Donna B. Sparks

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02873

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Edward Majesky
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 7:23 P.M.

4a. Facility Name (If not institution, give street and number): Civista Medical Center
4b. City, Town, or Location of Death: LaPlata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 235-24-7215
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 20, 1926
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: California
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 44043 Flagstone Way
10f. Zip Code: 20619
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4or 5+): 5 years
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Commissioned Officer
16b. Kind of Business/Industry: United States Navy

17. Father's Name (First, Middle, Last): John Herman Majesky
18. Mother's Name (First, Middle, Maiden Surname): Marjorie Crawford Meyer

19a. Informant's Name/Relationship (Type, Print): Eve E. Majesky (Spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 44043 Flagstone Way, California, Maryland 20619

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Brinsfield-Echols | Date: 1/17/2001
20c. Location - City or Town, State: Charlotte Hall, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Parkinson's Disease	1991
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Prostate Cancer	
	Due to (or as a consequence of):	
	c. Dementia	
	Due to (or as a consequence of):	
	d. Anemia	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Parul Jani MD
29c. License number: D45092
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Parul Jani 110 Hospital Road, Suite #303, Prince Frederick, Maryland 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0113-037
crn
Dennie Scott Mowry

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02874

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Dennie Scott Mowry
2. Dete of Death (Month, Day, Year): January 06, 2001
3. Time of Death: 7:54 P.M.
4e Facility Name (If not institution, give street and number): St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Deeth: St. Mary's

Funeral Director

5. Social Security Number: 162-44-9714
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthdey): 48 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Yeer): Aug. 19,1952
9. Birthplace (Stete or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 26460 Anne Court
10f. Zip Code: 20659
10g. Citizen of What Country?: U. S. A.

11. Meritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): / College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Owner / Operator
16b. Kind of Buelness/Industry: Convenience Store
17. Fether's Neme (First, Middle, Last): William Mowry
18. Mother's Neme (First, Middle, Maiden Surname): Sadie Ruth Brown
19a. Informent's Neme/Reletionship (Type, Print): Barbara A. Mowry / Wife
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26460 Anne Court Mechanicsville, Maryland 20659
20e. Method of Disposition: 1☐Burlel 2☒Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Brinsfield-Echols Crem.
Date: JAN. 11,2001
20c. Location - City or Town, State: Charlotte Hall, MD
21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Fecility: Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd. Charlotte Hall, MD 20622

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. Approximate Interval Between Onset and Deeth

Immediete Cause (Finel disease or condition resulting in death): a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or es e consequence of):
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Lest:
b.
Due to (or as e consequence of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Wes an eutopsy performed? PARTIAL 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☒Yes 2☐No

25. Wes cese referred to medicel exeminer? 1☒Yes 2☐No
26. Place of Deeth (Check only one): Hospitel: 1☐Inpetient 2☒ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined
28a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, Stete):

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner as stated. 2☒ **Medical Examiner**: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end menner stated.
29b. Signature end title of certifier: [signature] M.D.
29c. License number: O.C.M.E.
29d. Dete signed (Month, Dey, Yeer): January 08, 2001
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 10 2001
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02875

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ernest Charles Morris
2. Date of Death Month Day Year: JANUARY 03, 2001
3. Time of Death: 10:30PM
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-16-1049
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: September 21, 1912
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Abell
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 20614 Golden Thompson Road
10f. Zip Code: 20606
10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U,S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indian, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8th | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waterman
16b. Kind of Business/Industry: Seafood

17. Father's Neme *(First, Middle, Last)*: Foster Morris
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Francis Geneva Ellis

19a. Informent's Name/Reletionship *(Type, Print)*: R. Thelma Morris (Spouse)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 20614 Golden Thompson Road, Abell, Maryland 20606

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Sacred Heart Cemetery | Dete: 1/6/2001
20c. Location - City or Town, Stete: Bushwood, Maryland 20618

21. Signeture of Funerel Service Licensee: Michael Kevin Gardiner Jr.
22. Neme end Address of Fecility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Cause (Finel disease or condition resulting in deeth):
a. Acute Myocardial Infarction — Approximate Interval: Between Onset and Death: unknown
Due to (or as a consequence of):
b. coronary artery disease
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Last

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medicei examiner? 1 [ ] Yes 2 [X] No
26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [X] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Menner of Death: 1 [X] Neturei 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier
29c. License number: D19917
29d. Date signed *(Month, Day, Year)*: 1/4/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): DR. JAMES BOYD CALIAFORNIA ,MD. 20619

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 05 2001
32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: RENEST CHARLES MORRIS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02876

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Lee Michalsky
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 2000
4a. Facility Name (If not institution, give street and number): Beverly Healthcare
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 192-30-1573
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 9, 1938
9. Birthplace (State or Foreign Country): Waynesboro, PA

Usual Residence of Decedant

10a. State: PA
10b. County: Franklin
10c. City, Town or Location: Waynesboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 224 Harrison Ave
10f. Zip Code: 17268
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accountant
16b. Kind of Business/Industry: Truck Mfg

17. Father's Name (First, Middle, Last): Theodore Z. Michalsky
18. Mother's Name (First, Middle, Maiden Surname): Martha M. McKean

19a. Informant's Name/Relationship (Type, Print): Karen J. Robinson Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 120 Harbaugh Ave Waynesboro PA 17268

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): Green Hill Cemetery | Date: Jan 20
20c. Location - City or Town, State: Waynesboro PA 17268

21. Signature of Funeral Service Licensee: James A. Bowersox
22. Name and Address of Facility: Grove-Bowersox Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17268

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Arrest — 36 minutes
Due to (or as a consequence of):
b. Chronic Obstructive Lung Disease w/ Acute Exacerbation
Due to (or as a consequence of):
c. History of Nicotine Addiction
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
1) Diabetes Mellitus,
2) Multiple Gangrene Toes Fingers,
3) Coronary Artery Disease 4) End Stage Renal Failure

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D27898
29d. Date signed (Month, Day, Year): 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. FRANCISCO J. ANDRADE 350 MILL ST, Hagerstown MD 21740

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02877

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jack Henry MARTYN
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 09:55 am
4a. Facility Name (If not institution, give street and number): 7525 B Street
4b. City, Town, or Location of Death: Chesapeake Beach
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 213 14 9455
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 79 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 28, 1921
9. Birthplace (State or Foreign Country): Wash., DC

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: Chesapeake Beach
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7525 B Street
10f. Zip Code: 20732
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): machinist
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): John Henry Martyn
18. Mother's Name (First, Middle, Maiden Surname): Florence Helen Huhn

19a. Informant's Name/Relationship (Type, Print): Dorothy F. Martyn (daug.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7419 B Street, Chesapeake Beach, MD 20732

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery
Date: 1-25-01
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE MYO CARDIAL INFARCTION — MINUTES
Due to (or as a consequence of):
b. CORONARY ARTERY DISEASE — YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC OBSTRUCTIVE PULMONARY DISEASE
DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: D26358
29d. Date signed (Month, Day, Year): JAN. 19 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN WEIGEL, MD - PRINCE FREDERICK, MD - 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15
1 VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02878

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM B. MIDDLETON
2. Date of Death Month / Day / Year: January 15, 2001
3. Time of Death: 8:15PM

4a. Facility Name *(If not institution, give street and number)*: 902 Merck Place
4b. City, Town, or Location of Death: Ft. Washington
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-36-7515
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 30, 1929
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 902 Merck Place
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Janitor
16b. Kind of Business/Industry: US Gov't./ GSA

17. Father's Name *(First, Middle, Last)*: Ollie Middleton
18. Mother's Name *(First, Middle, Maiden Surname)*: Ophelia Hawkins

19a. Informant's Name/Relationship *(Type, Print)*: Marietta Brown/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 902 Merck Place, Ft. Washington, MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery
Date: 1/19/2001
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: ▶ Tonya Montgomery-Cheatham
22. Name and Address of Facility: CEDAR HILL FUNERAL HOME, INC. 4111 Pennsylvania Ave., Suitland, MD 20746

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Collapse

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Congestive Cardiomyopathy

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Victor E. Henry MD
29c. License number: D20986
29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Victor E. Henry 9131 Piscataway Rd., Clinton, MD 20735

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: ▶ pending B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02879

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward William Matthews
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 7:06PM
4a. Facility Name (If not institution, give street and number): 2010 D. Wedgewood Place
4b. City, Town, or Location of Death: Waldorf
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 214-72-3587
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 48 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 11,1952
9. Birthplace (State or Foreign Country): Washington,D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Waldorf
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 2010 D. Wedgewood Place
10f. Zip Code: 20602
10g. Citizen of What Country?: United States

11. Marital Status: ☒1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School, Teacher
16b. Kind of Business/Industry: Southern College of Maryland

17. Father's Name (First, Middle, Last): Edward Matthews
18. Mother's Name (First, Middle, Maiden Surname): Lucille Conner

19a. Informant's Name/Reletionship (Type, Print): Edward Matthews(Father)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 218 Brent Rd, Waldorf, Maryland 20602

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lee Crematory — Date: January 17,2001
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Walter D. Lee
22. Name and Address of Facility: Lee Funeral Home, INC 6633 Old Alexander Ferry Road, Clinton, Md. 20735

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure

Due to (or as a consequence of): b. End Stage muscular dystrophy

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner atated.

29b. Signature and title of certifier: Collins Po Sein
29c. Licensa number: D46979
29d. Date signed (Month, Day, Year): 1-15-2001

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Collins Po Sein 11345 Pembrooke Sq. #104 Waldorf MD 20603

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signatura: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02880

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Louise Naylor
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 12:20 PM
4a. Facility Name (If not institution, give street and number): Stella Maris Hospice
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-34-0580
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 6, 1936
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3901 Hannon Ct., Unit A
10f. Zip Code: 21236
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Loan Officer
16b. Kind of Business/Industry: Credit Union

17. Father's Name (First, Middle, Last): Louis C. Rehak
18. Mother's Name (First, Middle, Maiden Surname): Matilda Benda

19a. Informant's Name/Relationship (Type, Print): Mr. Robert L. Naylor (husband)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3901 Hannon Ct., Unit A, Baltimore, MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gardens of Faith Cem.
Date: 1/20/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian A Miller
22. Name and Address of Facility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Empyema

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year):
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred:
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):
28f. Location (Street and Number or Rural Route Number, City or Town, State):

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: ▶ [signature]
29c. License number: D43725
29d. Date signed (Month, Day, Year): 1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

January 16, 2001 12:20 p.m.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Mary Louise Naylor

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02881

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aliese Hazel Nichols

2. Date of Death (Month, Day, Year): January 15, 2001

3. Time of Death: 3:05am

4a. Facility Name (If not institution, give street and number): Springbrook Adventist Health Care

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 185-09-0328

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 16, 1912

9. Birthplace (State or Foreign Country): Penna.

Usual Residence of Decedent

10a. State: Md

10b. County: Prince George's

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 133 Arden Way

10f. Zip Code: 20707

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk/Analyst

16b. Kind of Business/Industry: NASA, Fed.Gov't

17. Father's Name (First, Middle, Last): Matthew Haven Nutter

18. Mother's Name (First, Middle, Maiden Surname): Sadie Lisby

19a. Informant's Neme/Relationship (Type, Print): Dolores Carter/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15420 Durant Street, Silver Spring, Md 20905

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crem.

Date: 1/17/01

20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: Philip D. Rinaldi

22. Name and Address of Facility: Philip D.Rinaldi Funeral Service 11818 New Hampshire Ave.Silver Spring,Md

To Be Completed by Funeral Director

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute myocardial infarction — Sudden

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Atherosclerotic heart disease — years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
atherosclerotic vascular disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter M. Schuster MD

29c. License number: D22780

29d. Date signed (Month, Day, Year): 1/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M Schuster MD 7500 Greenway Ctr Dr. Greenbelt, Md 20770

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrer's Signeture: Barbara G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02882

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Betty Jane Nichols

2. Date of Death Month Day Year: Jan. 18, 2001

3. Time of Death: 2242

4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 215-62-1087

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 47 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan 31, 1953

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Caroline

10c. City, Town or Location: Ridgely

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5 Park Ave.

10f. Zip Code: 21660

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: nursing aide

16b. Kind of Business/Industry: elderly

17. Father's Name *(First, Middle, Last)*: Clarence G. Schmitt

18. Mother's Name *(First, Middle, Maiden Surname)*: Annie E. Burns Schmitt

19a. Informant's Name/Relationship *(Type, Print)*: Kevin Lee Schmitt/ son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 103 Tilghman, Maryland 21671

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Greensboro Cemetery

Date: 1/22

20c. Location - City or Town, State: Greensboro, MD

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Fleegle - Helfenbein Funeral Home, PA P.O. Box 160 Greensboro, MD 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cervical carcinoma

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D0047534

29d. Date signed *(Month, Day, Year)*: 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Wafik Zaki 920 Market Street Denton, Maryland 21629

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: ▶ [signature] G. Sparks

Betty Jane Nichols
Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM#17 & 18 HCHD 1-24-01 LM

Certificate of Death

Reg. No. 2001 02883

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary E. Ossman

2. Date of Death Month / Day / Year: January 16, 2001

3. Time of Death: 2140

4a. Facility Name *(If not institution, give street and number)*: St. Joseph Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-09-4429

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 93 Yrs.

If Under 1 Yaer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 27, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9225 Gardenia Road

10f. Zip Code: 21236

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 8th Grade; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Giva kind of work done during most of working life. DO NOT usa retired)*: Finger Printer

16b. Kind of Business/Industry: Manufacturing

17. Father's Neme *(First, Middle, Last)*: ~~Frank Mech~~ Frederick Mech

18. Mother's Name *(First, Middle, Maiden Surneme)*: ~~Lucinda~~ Carrie Harmon

19a. Informent's Neme/Reletionship *(Type, Print)*: Mrs. Edith Marinelli (daughter)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9225 Gardenia Road, Baltimore, MD 21236

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gardens of Faith Cem.

Dete: 1/19/01

20c. Location - City or Town, Stete: Baltimore, Maryland

21. Signature of Funerel Service Licensee: ▶ Mark T. Zo...

22. Name end Address of Fecility: Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert failure. List only one cause on aech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in deeth) e. Septic shock

Due to (or as a consequence of): Acute Abdomen

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b. Due to (or as a deosequence of): Severe Dehydration

c. Due to (or as a consequence of):

d.

Part II. **Other signifiicant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

dementia

UTI

multiinfarct Dementia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Piece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: ▶ F. Kouli

29c. License number: D48271

29d. Date signed *(Month, Day, Year)*: 1-18-01

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): FAHED KOULI, M.D., 7600 OSLER DR., S-411, TOWSON, MD 21204

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signeture: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

P.D.

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02884

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
ANN M. O'HARA	JAN. 16, 2001	1:45 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
600 HOOK RD.	WESTMINSTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-38-0279	1☐ M 2☒ F	68 Yrs.			6/19/1932	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
W. VA.	HAMPSHIRE	SPRINGFIELD	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
HC 86, Box 15-4	26763-9705	USA.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		HOUSEWIFE	HOME MAKER

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
GLENN H. SMITH	AGNES L. BOYD

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MICHAEL O'HARA - SON	29 WESTMORELAND ST., WESTMINSTER, MD. 21157

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	METRO CREMATORY	1/17/01	BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: FLETCHER FUNERAL HOME, 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ASCUN	minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Colon Cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☑ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify) DAUGHTER'S HOME

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	0005192 4	January 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Herbert P. Henderson Jr. MD 295 Stoner Ave Suite 307 Westminster MD 21157

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 18 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02885

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Timothy Jerome O'Brien

2. Date of Death: Month January Day 25 Year 2001

3. Time of Death: 2107

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 374 30 6264

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 27 1931

9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Lusby

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13535 Marine Avenue

10f. Zip Code: 20657

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 51-55

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify*: white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Educator

16b. Kind of Business/Industry: Crestwood schools

17. Father's Name *(First, Middle, Last)*: Jerome O'Brien

18. Mother's Name *(First, Middle, Maiden Surname)*: Marion D"Antoni

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Jo O'Brien - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13535 Marine Ave. Lusby, Maryland 20657

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: Jan 28, 2001

20c. Location - City or Town, State: Alexandria Virginia

21. Signature of Funeral Service Licensee: MO1095

22. Name and Address of Facility: Rausch Funeral Home P.A. 4405 Broomes Is. Rd. Port Republic MD 20676

Physician /Medical Examiner

23a. Part1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sudden Death

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D Denekas

29c. License number: D 30842

29d. Date signed *(Month, Day, Year)*: Jan 25 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Denekas, MD Hospital Rd. Prince Frederick MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 30 2001

32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

15+1 grads

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02886

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James E. Owens, Jr.

2. Date of Death — Month: Jan. Day: 13 Year: 2001

3. Time of Death: 2:05 P.M.

4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center

4b. City, Town, or Location of Death: Crofton

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577 44 6436

8. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: July 25, 1933

9. Birthplace *(State or Foreign Country)*: Washington D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Crofton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1601 Mt. Airy Court

10f. Zip Code: 21114

10g. Citizen of What Country?: United States

11. Meritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Detective-D.C. Police

16b. Kind of Business/Industry: Police Department

17. Father's Neme *(First, Middle, Last)*: James E. Owens, Sr.

18. Mother's Neme *(First, Middle, Meiden Surname)*: Kathryne Dodson

19e. Informent's Neme/Reletionship *(Type, Print)*: Kathleen Owens Wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1601 Mt. Airy Court Crofton Maryland 21114

20e. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Maryland Veterans Cemetery Date: Jan. 18, 2001

20c. Location - City or Town, Stete: Crownsville Maryland

21. Signature of Funeral Service Licensee: Robert E. Bisler

22. Name end Address of Facility: Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications, thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel diseasa or condition resulting in deeth)

a. Coronary artery disease — Due to (or es a consequence of): — 5 years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in death) Last

b. — Due to (or es a consequence of):

c. — Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. 2 [ ] **Medical Examinar:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the cause(s) and manner steted.

29b. Signature and title of certifier: Satbir Singh

29c. License number: D 38458

29d. Dete signed *(Month, Day, Year)*: 1/15/1

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dalgeit Singh Sidhu 1413 Annapolis Rd. #106 odenton MD 21113

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 19 2001

32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02887

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Emory Allen Pinkard

2. Date of Death Month Day Year: January 16, 2001

3. Time of Death: 8:07AM

4a Facility Name *(If not institution, give street and number)*: 10700 Mullikin Drive

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 229-28-2796

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 20, 1928

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 10700 Mullikin Drive

10f. Zip Code: 20735

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1950-1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Meat Cutter

16b. Kind of Business/Industry: Meat Company

17. Father's Name *(First, Middle, Last)*: Elwood Alonza Pinkard

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Janie Ella Wilkins

19a. Informant's Name/Relationship *(Type, Print)*: William Pinkard (Son)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 5947 East Boniwood Turn Clinton, Maryland 20735

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Trinity Memorial Gardens; Date: January 19, 2001

20c. Location - City or Town, State: Waldorf, Maryland

21. Signature of Funeral Service Licensee: Wm D. DuPont

22. Nama and Address of Facility: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735

GP

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death) a. METASTATIC PROSTATE CANCER — 6 YEARS

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: Gupta MD

29c. License number: D43346

29d. Date signed *(Month, Day, Year)*: 1/17/01

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Rita Gupta, M.D. 8926 Woodyard Road # 201 Clinton, Maryland 20735

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10
10A

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02888

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANTHONY J. PRINGLE
2. Date of Death: Month JANUARY Day 20 Year 2001
3. Time of Death: 12:12 p.m.
4a. Facility Name (If not institution, give street and number): Veterans Administration Hospital Baltimore
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: —

Funeral Director

5. Social Security Number: 215-34-8013
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Aug. 18, 1937
9. Birthplace (State or Foreign Country): England

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3804 Elmley Avenue
10f. Zip Code: 21213
10g. Citizen of What Country?: U. S. A..

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th Grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Forklift Operator
16b. Kind of Business/Industry: Brewery

17. Father's Name (First, Middle, Last): George Pringle
18. Mother's Name (First, Middle, Maiden Surname): Anna Jones

19a. Informant's Name/Relationship (Type, Print): Mrs. Emily Pringle (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3804 Elmley Avenue, Baltimore, Maryland 21213

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Veterans Cem.
Date: 1/24/01
20c. Location - City or Town, State: Owings Mills, Maryland

21. Signature of Funeral Service Licensee: Brian G. Schimunek
22. Name and Address of Facility: Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Md. 21213

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	SEPSIS	2 weeks
Due to (or as a consequence of): b.	Necrotizing fasciitis	3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Date of Injury (Month, Day Year)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD.
29c. License number: P13891
29d. Date signed (Month, Day, Year): January 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BENJAMIN LAWRITTY 29 S. Caroline St. Baltimore, MD 21209

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: [signature]

ORIGINAL

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

BF

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02889

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Iva Celeste PHIPPS
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 12:50 pm
4a. Facility Name *(If not institution, give street and number)*: Millennium Health & Rehabilitation Center
4b. City, Town, or Location of Death: Edgewater
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213 22 1290
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 3, 1904
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 144 Washington Road
10f. Zip Code: 21037
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: factory worker
16b. Kind of Business/Industry: plastics

17. Father's Name *(First, Middle, Last)*: Lee Brady
18. Mother's Name *(First, Middle, Maiden Surname)*: Lucy Smith

19a. Informant's Name/Relationship *(Type, Print)*: Mattie L. Phipps (daug.-in-law)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7086 Prout Rd., Friendship, MD 20578

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Mem. Cemetery
Date: 1-24-01
20c. Location - City or Town, State: Annapolis, MD

21. Signeture of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. ASCVD — 1 0 2 5

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.: HYPOTN 2 0 1 5 1 5 M

23b. Did **tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to compietion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Piace of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, offica builiding, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end piece, and due to the ceuse(s) end menner es stated. 2☐ **Medical Exeminer:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: D-04601
29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Raymond Caplan, M.D. Pikesville, MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 24 2001
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02890

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ella Fowler Pitcher

2. Date of Death (Month, Day, Year): January 18, 2001

3. Time of Death: 9:20 P.M.

4a. Facility Name *(If not institution, give street and number)*: 4102 School Road

4b. City, Town, or Location of Death: Broomes Island

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 220-34-7780

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 22, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Calvert

10c. City, Town or Location: Broomes Island

10d. Inside City Limits: 1☐ Yes ☒ No

10e. Street and Number: 4102 School Road

10f. Zip Code: 20615

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unit Secretary

16b. Kind of Business/Industry: Calvert Memorial Hospital

17. Father's Name *(First, Middle, Last)*: James Phillip Tayman

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Cleveland Fowler

19a. Informant's Name/Relationship *(Type, Print)*: James V. Pitcher - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4085 School Road Broomes Island, MD 20615

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Broomes Island Cemetery | Date: Jan. 22, 2001

20c. Location - City or Town, State: Broomes Island Maryland

21. Signature of Funeral Service Licensee: BRausch

22. Name and Address of Facility: Rausch Funeral Home, P.A. 4405 Broomes Island Rd. Port Republic, MD 20676

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Light Chain Myeloma.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

2 years.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure,

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Zahir Yousaf MD

29c. License number: D0027189

29d. Date signed *(Month, Day, Year)*: 1/19/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Zahir Yousaf, M.D. 2417 Solomons Island Rd. North Huntingtown, MD 20639

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

01-0234-033
CJ
David Perry Price

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02891

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
David Perry Price	January	14	2001	00:57 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Prince George's Hospital Center	Cheverly	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
223453883	1 X M 2 ☐ F	21 Yrs.					9/18/79	VA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
VA	None	Alexandria	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
312 North Fayette St	22314	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		Asst. Librarian	Gov't Contract

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leroy Price	Paula Lyles

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paula Price(Mother)	312 N. Fayette ST, Alexandria, VA 22314

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bethel Cemetery	1/21/2001	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Nels E Greene	Greene Funeral Home Inc 814 Franklin ST, Alexandria, VA 22314

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Gunshot Wound to Left Groin	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 X Yes 2 ☐ No	1 X Yes 2 ☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 X Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	1-13-1	1825 M	1 ☐ Yes 2 X No	Subject Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Street	2500 Bent Village Landover

29a. Certifier (Check only one) 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	O.C.M.E.	January 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 16 2001	▶ G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

CF

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02892

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret F. Purdin
2. Date of Death (Month, Day, Year): January 13, 2001
3. Time of Death: 9:03 AM
4a. Facility Name *(If not institution, give street and number)*: 2029 Seattle Avenue
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 474-26-2806
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 95 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 17, 1905
9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residance of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Locafion: Silver Spring
10d. Inside City Limits: 1☐ Yas 2☒ No
10e. Streef and Number: 2029 Seattle Avenue
10f. Zip Code: 20904
10g. Citizen of Whet Country?: USA

11. Marital Sfafus: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedenf Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elemantary/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Charles Duke
18. Mother's Nama *(First, Middle, Maiden Surneme)*: Mary Melinda Binkard

19a. Informent's Neme/Relationship *(Type, Print)*: Michael Hanson / Son
19b. Malling Addrass *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 9920 Gardiner Avenue, Silver Spring, Maryland 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cramafion 3☐ Ramoval from Stata 4☐ Donetion 5☐ Othar *(Specify)*
20b. Piece of Disposition *(Nema of cemefery, crematory or other piece)*: Des Moines Masonic Cem. — Dafe: 01/20/01
20c. Locafion - City or Town, Stete: Des Moines, Iowa

21. Signature of Funaral Service Licensee: Alan J. Domnell
22. Name end Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrast, shock, or heert failure. List only one ceuse on eech line.

Approximate Intarvel Batween Onset and Deeth

Immedeite Cause (Finel diseese or condition resulting in daeth)
a. Failure to Thrive — 1 year

Due to (or es a consequence of):
b. Congestive Heart Failure — 5 years

Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Disaese or injury thet initiated events resulting in deeth) Last
Due to (or es e consequence of):
c.
Dua fo (or es a consequence of):
d.

Part II. **Other aignificant conditiona** contributing to death but not resulting in the underlying ceuse givan in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Was casa referred to medical examinar? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Othar *(Specify)*
27. Mannar of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, data and place, end due to tha causa(s) and menner es stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, daath occurred at tha tima, data and place, end due to the ceuse(s) and menner steted.
29b. Signature and title of certifiar: Mark Parkhurst, M.D.
29c. License number: D24093
29d. Date signed *(Month, Day, Year)*: January 17, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Mark Parkhurst, M.D. 7305 Baltimore Avenue, #107, College Park, Maryland 20740

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signeture: Penny G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02893

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NELSON B PHELPS.

2. Date of Death Month / Day / Year: January 14, 2001

3. Time of Death: 08:23

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212 20 0876

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 75 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 23, 1925

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 20 Greystone Court Unit K

10f. Zip Code: 21403

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Printer

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Walter Samuel Phelps

18. Mother's Name *(First, Middle, Meiden Surneme)*: Estella Mae Clark

19a. Informent's Neme/Reietionship *(Type, Print)*: Donald Phelps / Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 132 Shoreline Drive Pittsburg, California 94565

20a. Method of Disposition: 1 [X] Buriei 2 [ ] Cremetion 3 [ ] Ramovat from Stata 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other pieca)*: Fort Lincoln Cemetery

Date: 1-19-01

20c. Location - City or Town, Steta: Brentwood, Maryland

21. Signature of Funerel Service Licensee: Nicoles

22. Name end Addrass of Feciiity: Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, Maryland 20722

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complications thet caused tha deeth. Do not anter the mode of dying, such as cardiac or raspiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Cause (Finel diseese or condition resulting in deeth)

a. PNEUMONIA — 1 week

Dua to (or es a consequenca of):

Sequentiatly tist conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b. MYELODYSPLASTIC SYNDROME — 5 yr.

Due to (or as e consequenca of):

c.

Dua to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.: RENAL INSUFFICIENCY.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [ ] No

25. Was case rafarred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [ ] Neturat 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete and pieca, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Harvey J Steinfeld MD

29c. Licansa number: D05158

29d. Data signed *(Month, Day, Year)*: 01/14/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): HARVEY STEINFELD, M.D 6131 SHADYSIDE RD SHADYSIDE, MD 20764

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrer's Signetura: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 25a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

BJ

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02894

Physician /Medical Examiner

Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Mary I. Richter

2. Date of Death Month Day Year: January 13, 2001

3. Time of Death: 7:50 pm

4a. Facility Name *(If not institution, give street and number)*: Ft. Washington Medical Center

4b. City, Town, or Location of Death: Ft. Washington

4c. County of Death: Prince George's

5. Social Security Number: 219-05-6497

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 31,1917

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Ft. Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12021 Livingston Road

10f. Zip Code: 20744

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Dept. of Army

17. Father's Name *(First, Middle, Last)*: Jim Isley

18. Mother's Neme *(First, Middle, Maiden Surname)*: Hassie (unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Patricia Wright - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 802 Irvington Street, Oxon Hill, Maryland 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven

Date: 1-19-01

20c. Location - City or Town, Stete: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Kimberly C Bratton

22. Name and Address of Facility: Marshall's Funeral Home of MD, 4308 Suitland Road, Suitland, MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

a. COMPLETE HEART BLOCK — MINUTES

Due to (or es a consequence of):

b. CORONARY ARTERY DISEASE — 4 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D12906

29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Louis Kaufman, M.D. 12070 Old Line Center, Suite #207, Waldorf, Maryland

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signeture: G. Sparks

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02895

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charlotte I. Regelmann
2. Date of Death Month Day Year: January 11, 2001
3. Time of Death: 9:00 am
4e. Facility Name *(If not institution, give street and number)*: Haven Assisted Care
4b. City, Town, or Location of Death: Potomac
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 161-32-2892
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jun 5, 1915
9. Birthplace *(State or Foreign Country)*: Poland

Usual Residence of Decedent

10a. State: VA
10b. County: Fairfax
10c. City, Town or Location: Vienna
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1009 Rachel La. SW
10f. Zip Code: 22180
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tailor
16b. Kind of Business/Industry: Dress Maker

17. Father's Name *(First, Middle, Last)*: Oskar Radke
18. Mother's Neme *(First, Middle, Maiden Surname)*: Hedwig Fuhrman

19a. Informant's Name/Relationship *(Type, Print)*: Ursula Wohlfahrt/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1009 Rachel La. SW Vienna , VA 22180

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Name of cametery, crematory or other placa)*: Mt. Rose Cemetery
Date: Jan 15 2001
20c. Location - City or Town, State: York, PA

21. Signature of Funeral Service Licensee: ▶ Beverly L. Helmtte
22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death): a. PNEUMONIA.

Due to (or as a consequence of): SEPSIS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 8☒ Other *(Specify)* Assited living
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date ot Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mennar as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piaca, and due to tha cause(s) end manner steted.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: H 51280
29d. Date signed *(Month, Day, Year)*: 1-11-2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Anushiruan Dadgar M.D. 13219 Executive Park Terrace, Germantown, MD 20874

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001 (penna)
32. Registrar's Signature: ▶ D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02896

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Stanley Rubin
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 6:20 AM
4a. Facility Name *(If not institution, give street and number)*: 4406 Elm St.
4b. City, Town, or Location of Death: Chevy Chase
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 280-36-3461
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jun 7, 1938
9. Birthplace *(State or Foreign Country)*: OH

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4406 Elm St.
10f. Zip Code: 20815
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Program Officer
16b. Kind of Business/Industry: U.S. State Dept.

17. Father's Name *(First, Middle, Last)*: Charles Rubinstein
18. Mother's Name *(First, Middle, Maiden Surname)*: Selma (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Barbara Rubin /Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4406 Elm St., Chevy Chase, MD 20815

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory — Date: Jan 13 2001
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Beverly L. Herbatte
22. Name and Address of Facility: Rapp Funeral Home & Cremation Services 933 Gist Ave. Silver Spring, MD

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Glioblastoma Multiforme	3 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — b.		
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Allen M Mondzac
29c. License number: DC3820
29d. Date signed *(Month, Day, Year)*: 1/13/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen M Mondzac M.D. 2141 K St. N.W. Washington, DC 20037

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02897

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Keith J. Raynor
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 10:37AM
4a. Facility Name (If not institution, give street and number): 2837 Scarff Road
4b. City, Town, or Location of Death: Fallston
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-92-8051
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 37 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09/05/1963
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Fallston
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 2837 Scarff Road
10f. Zip Code: 21047
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Automobile
17. Father's Name (First, Middle, Last): Charles H. Raynor
18. Mother's Name (First, Middle, Maiden Surname): Charlotte M. Pitta
19a. Informant's Name/Relationship (Type, Print): Mr. Glenn Raynor (Brother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1604 Bramble Court, Bel Air, Maryland 21015
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Gardens | Date: 01/22/01
20c. Location - City or Town, State: Bel Air, Maryland
21. Signature of Funeral Service Licensee: Christina L. David
22. Name and Address of Facility: Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd., Bel Air, Maryland 21014

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebral Herniation
Due to (or as a consequence of):
b. Cerebral Edema
Due to (or as a consequence of):
c. Anaplastic Astrocytoma
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: AN41764B5R1243D
29d. Date signed (Month, Day, Year): 1/23/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BIMAL RAMI 22 South Greene St Balt. MD

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

BN

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02898

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William John Reed
2. Date of Death (Month, Day, Year): JANUARY 17, 2001
3. Time of Death: 1:48AM
4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 043-14-2434
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 13, 1921
9. Birthplace *(State or Foreign Country)*: USA, Connecticut

Usual Residence of Decedent

10a. State: MD
10b. County: St. Mary's
10c. City, Town or Location: Great Mills
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 20490 Adkins Road
10f. Zip Code: 20634
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief Pharmacist Mate
16b. Kind of Business/Industry: US Navy

17. Father's Name *(First, Middle, Last)*: Gordon M. Reed
18. Mother's Name *(First, Middle, Maiden Surname)*: Wilhemenia Mehrtens

19a. Informant's Name/Relationship *(Type, Print)*: Edwina Reed
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20490 Adkins Road, P.O. Box 177, Great Mills, MD 20634

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 1/19/01
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Michael Lewis Gardner
22. Name and Address of Facility: Mattingley-GardinerFuneral Home P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis — Several days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Non Hodgkins Lymphoma — years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Previous Brain Surgery. Chronic Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: David M. Federle MD
29c. License number: 34198
29d. Date signed *(Month, Day, Year)*: 1/17/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. DAVID FEDERLE HOLLYWOOD, MD. 20636

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DR. WILLIAM JOHN REED

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02899

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sheldon George Russell
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 9:58 a.m.
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 216-12-4877
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 2, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Tall Timbers
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 45226 Lighthouse Road
10f. Zip Code: 20690
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Charter Boat Captain
16b. Kind of Business/Industry: Commercial Fisherman

17. Father's Name (First, Middle, Last): George Washington Russell
18. Mother's Name (First, Middle, Maiden Surname): Sarah Shorter

19a. Informant's Name/Relationship (Type, Print): Winifred C. Russell / Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45226 Lighthouse Road, Tall Timbers, Maryland 20690

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. George's Episcopal — Date: 1-15-01
20c. Location - City or Town, State: Valley Lee, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Pneumonia — DAYS

Due to (or as a consequence of):
b. Emphysema + Chronic Obstructive Lung Disease — YRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease

23b. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D36601
29d. Date signed (Month, Day, Year): 01/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID M. BRILL, MD 7600 CARROLL AVE. TAKOMA PARK MD 20912

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02900

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Austin Granvel Rinker
2. Date of Death Month Day Year: January 17, 2001
3. Time of Death: 2:00 a. m.
4a. Facility Name *(If not institution, give street and number)*: 1020 Oxford Circle
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 217-20-9214
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 28, 1928
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1020 Oxford Circle
10f. Zip Code: 21740
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: 1943 - 86
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Administrative Specialists
16b. Kind of Business/Industry: U. S. Army

17. Father's Name *(First, Middle, Last)*: Theodore Elwood Rinker
18. Mother's Name *(First, Middle, Maiden Surname)*: Mina Evelyn Allender

19a. Informant's Name/Relationship *(Type, Print)*: Cathryn M. Rinker Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1020 Oxford Circle Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Rose Hill Cemetery — Date: 1/20/01
20c. Location - City or Town, Stete: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnick
22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, Maryland 21740

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final diseeae or condition resulting in death): a. Myocardial Infaction
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: Lymphoma

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner**: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Allen Tsui
29c. License number: D0055072
29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Allen Tsui 24 N. Walnut Street Hagerstown MD 21740

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02901

Robinson, Charles William

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES William ROBINSON
2. Date of Death: Month January Day 19 Year 2001
3. Time of Death: 1255 Hrs.
4a. Facility Name (If not institution, give street and number): WASHINGTON County Hospital
4b. City, Town, or Location of Death: HAGERSTOWN, MD
4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 219-14-8969
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV. 24, 1921
9. Birthplace (State or Foreign Country): PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Clear Spring
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 14364 Hicksville Rd.
10f. Zip Code: 21722
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd grade; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Agriculture

17. Father's Name (First, Middle, Last): Fred Robinson
18. Mother's Name (First, Middle, Maiden Surname): Alice Smith

19a. Informant's Name/Relationship (Type, Print): Robert Kelley
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14850 Hicksville Rd. Clear Spring, MD 21722

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. Paul Cemetery
Date: Jan. 22, 2001
20c. Location - City or Town, State: Clear Spring, MD

21. Signature of Funeral Service Licensee: Major M. Robertson
22. Name and Address of Facility: Donald Edwin Thompson Funeral Home, Inc. P.O. BOX 310 Clear Spring, MD 21722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asystole
Due to (or as a consequence of):
b. Metabolic Acidosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Liver failure
Due to (or as a consequence of):
d. Metastatic Leimyosarcoma with Gastric Primary

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Mark S. Baron M.D.
29c. License number: D0053071
29d. Date signed (Month, Day, Year): 01/19/01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARK S. BARON, M.D. 11110 Medical Campus Rd, Ste 226, Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Donna D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02902

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE DAWSON REICHARD
2. Date of Death: Month January Day 22, Year 2001
3. Time of Death: 10:00 A.M.
4a. Facility Name (If not institution, give street and number): 1315 Oak Hill Avenue
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 270-24-7386
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 20, 1915
9. Birthplace (State or Foreign Country): Canada

Usual Residence of Decedent

10a. Stete: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 1315 Oak Hill Avenue
10f. Zip Code: 21742
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Co-owner
16b. Kind of Business/Industry: Bath Shop

17. Father's Name (First, Middle, Last): William Charles Dawson
18. Mother's Name (First, Middle, Meiden Surname): Kate Cochrane

19a. Informent's Neme/Reletionship (Type, Print): Barbara Coleman Witmer/Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1315 Oak Hill Avenue, Hagerstown, MD 21742

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Rose Hill Cemetery
Dete: Jan.25
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licetitee: ▶ [signature]
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part1. Enter the Disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediete Ceuse (Finel diseese or condition resulting in deeth) a.	Bronchogenic Carcinoma of the left lung	3 months
Due to (or as e consequence of): b.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or es a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Obliterative Peripheral artery disease

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and menner stated.

29b. Signetore end title of certifier: ▶ Robert Brull Personal Physician
29c. License number: D04359
29d. Date signed (Month, Day, Year): Jan 23 2001

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): Robert Brull MD 1459 Potomac Ave. Hagerstown, MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: [signature] D Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02903

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Langston W Ray
2. Date of Death (Month, Day, Year): January 18, 2001
3. Time of Death: 1:35AM
4a. Facility Name (If not institution, give street and number): Baltimore Rehabilitation and Extended Care
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 216-10-7075
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 17, 1917
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Sunderland
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 610 Ray Road
10f. Zip Coda: 20689
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, apecify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Raca - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housing Inspector
16b. Kind of Business/Industry: Federal Government

17. Father's Nama (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Fidela Ray

19a. Informant's Name/Relationship (Type, Print): Mildred Ray/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 610 Ray Road Sunderland, MD 20689

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar (Specify)
20b. Place of Disposition (Name of cemetary, crematory or othar place): Crownsville Veterans Cem.
Data: 1/24/01
20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: ▶ Gladys A. Sewell
22. Name and Address of Facility: Sewell Funeral Home, 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral vascular disease	2 years
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case rafarred to medical examinar? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [✓] Nursing Home 5 [ ] Residenca 8 [ ] Othar (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending invastigation 6 [ ] Could not be datarmined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician**: To the best of my knowledga, daath occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to tha cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD
29c. Licensa number: D0032548
29d. Data signed (Month, Day, Year): January 18, 2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): PERRY L COLVIN MD, 10 North Greene Street Baltimore Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: ▶ Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02904

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aaron Gene Roberts

2. Date of Death Month Day Year: January 12, 2001

3. Time of Death: 2:20 PM

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 224-09-8438

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 12, 1912

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 9711 Braddock Road

10f. Zip Code: 20903

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Research Scientist

16b. Kind of Business/Industry: National Bureau of Standards

17. Father's Name *(First, Middle, Last)*: Louis Leroy Roberts

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Grodzhenski

19a. Informant's Name/Relationship *(Type, Print)*: Honora Roberts / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9711 Braddock Road, Silver Spring, Maryland 20903

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Gar. Date: 01/15/01

20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hypotension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Kidney Failure

Due to (or as a consequence of):

c. Respiration Failure

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: H36078

29d. Date signed *(Month, Day, Year)*: 1-12-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEVEN FULLER 7600 Carroll Ave. Takoma Park, MD 20912

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001

32. Registrar's Signature: [signature] G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02905

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Minnie Richardson
2. Date of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 2:00pm
4e. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-30-1990
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 80 Yrs.
If Under 1 Yaer: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 20, 1920
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 324 17th St. S.E.
10f. Zip Code: 20003
10g. Citizen of What Country?: United States

11. Maritel Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuben, Maxican, Puarto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Black, White, atc. Specify: Black

15. Decedent's Education (Specify only highast grada compleated): Elamentary/Secondary (0-12): 10 / College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Custodian
16b. Kind of Businasa/Industry: Fed Govt

17. Fathar's Nama (First, Middla, Last): Willie Bryant
18. Mother's Nama (First, Middla, Maidan Sumama): Sara Franks

19a. Informant's Neme/Relationship (Type, Print): Eleanor Andrews /Daughter
19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2212 Porter Ave, Suitland, Md 20746

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Neme of cematary, cramatory or other piece): Maryland National Cemetery
Data: 1-23-01
20c. Location - City or Town, Stata: Laurel, Md

21. Signature of Funeral Service Licensee: Alex S Pope
22. Nama and Address of Facility: Alexander S. Pope Funeral Home, 5538 Marlboro Pike, Forestville, MD 20747

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that caused tha daath. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart feilure. List only ona ceusa on aach lina. — Approximata Intarval Between Onset and Daath

Immedieta Causa (Final disaesa or condition resulting in daath):
a. Cardiac Dysrhythmia
Dua to (or as a consequanca of):
b. Renal Failure

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Dua to (or as a consequance of):
c.
Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.: Hypertension, Diabetes Mellitus

23b. Did tobacco uas contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availeble prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☒ No

26. Place of Daath (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be detarmined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, deta end place, and due to the cause(s) and mannar stated.

29b. Signature and title of certifier: Attending Physician
29c. Licensa number: D0046374
29d. Data signed (Month, Day, Year): 1/18/01

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Anthony Thomas, MD 1328 Southern Ave SE Washington DC 20032

State Registrar

31. Data filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Richardson, Minnie #994534

6 3/6

Expired 01-16-01 @ 14:00

Dr. A. Thomas

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02906

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ASTON PATRICK REID

2. Date of Death Month / Day / Year: JANUARY 13, 2001

3. Time of Death: 1821

4a. Facility Name *(If not institution, give street and number)*: Shady Grove Adventist Hospital

4b. City, Town, or Location of Death: Rockville

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 212-57-0302

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 16, 1941

9. Birthplace *(State or Foreign Country)*: Jamaica

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Germantown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 18643 Turmeric Court

10f. Zip Code: 20874

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Jeweler

16b. Kind of Business/Industry: Jewelry

17. Father's Name *(First, Middle, Last)*: Jonathan Reid

18. Mother's Name *(First, Middle, Maiden Surname)*: Lois Castello

19a. Informant's Name/Relationship *(Type, Print)*: Bernadette Reid (Sister)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18643 Turmeric Ct., Germantown, MD 20874

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cem.

Date: 1/27/01

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: George R. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Proteus Mirabilis Septecemia — 6 hrs.

Due to (or as a consequence of):

b. Myocardial Infarction — minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Artheriosclerosis — years

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sonia M. Salmon, MD

29c. License number: D0042377

29d. Date signed *(Month, Day, Year)*: Jan. 16, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sonia M. Salmon, M.D. 4 Executive Park Ct., Germantown, MD 20874

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend#18 perFHG792 2/12/2001 EW

Certificate of Death

Reg. No. 2001 02907

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Millard Siler	January 09 2001	10:55 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Millennium Health & Rehabilitation of South River	Edgewater	Anne Arundel

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
244-42-5424	1[X] M 2[ ] F	70 Yrs.			October 19, 1930	North Carolina

Usuet Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Largo	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10129 Prince Pl. #303	20774	U.S.A.

11. Meritel Stetus	12. Wes Decedent Ever in U.S. Armed Forces?	13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Reca - American Indian, Bleck, White, etc.
1[ ] Never Married 2[X] Married 3[ ] Widowed 4[ ] Divorced	1[X] Yes 2[ ] No If Yes, Give Yeer or Detes:	1[ ] Yas 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamentary/Secondery (0-12)	College (1-4or 5+)		
12th		Mail Handler	Government

17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Surname)
Jerry Siler	~~Theodocia Viola Foxx~~ Thedocia Hannah

19a. Informant's Neme/Reletionship (Type, Print)	19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
Brenda K. Siler/Daughter	10129 Prince Pl. #303 Largo, MD 20774

20a. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Dete	20c. Location - City or Town, Stete
1[X] Burial 2[ ] Cremetion 3[ ] Removal from Stete 4[ ] Donetion 5[ ] Other (Specify)	Jordan Grove Cemetery	01/13/01	Siler City, N.C.

21. Signature of Funeral Service Licensee	22. Neme end Address of Feciliby
[signature]	J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or haert feilure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in death)	a. Cerebrovascular accident	2 wks
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immedieta cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Lest	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or es a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder
Type 2 Diabetes Mellitus
Hypertension

23b. Did tobacco use contribute to the cause of death? 1[ ] Yes 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1[ ] Yes 2[X] No	1[ ] Yas 2[ ] No

25. Was case referred to medical exeminer?	26. Plece of Death (Check only one)	
1[ ] Yes 2[X] No	Hospital: 1[ ] Inpatient 2[ ] ER/Outpatient 3[ ] DOA	Other: 4[X] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Manner of Death	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1[X] Neturel 2[ ] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending investigetion 6[ ] Could not be determined		M	1[ ] Yes 2[ ] No	
	28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one)	29b. Signeture and title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
1[X] Certifying Physician: To the best of my knowledge, daeth occurred et the time, data and plece, end dua to tha causa(s) and mannar as stated. 2[ ] Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, daath occurred at tha time, date and place, and dua to the cause(s) end manner steted.	[signature]	D48101	1/11/2001

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)
Donna Chambers MD 1833A Forest Dr Annapolis MD 21401

(10)

State Registrar

31. Date filed (Month, Dey, Year)	32. Registrer's Signetura
JAN 16 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02908

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Pearlie Mae Slater

2. Date of Death Month Day Year: Jan. 11, 2001

3. Time of Death: 11:05 a.m.

4a. Facility Name *(If not institution, give street and number)*: 25 Thurston Drive

4b. City, Town, or Location of Death: Upper Marlboro

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 244-58-7454

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 19, 1938

9. Birthplace *(State or Foreign Country)*: Laurinburg, N.C.

Usual Residence of Decedant

10a. State: Md.

10b. County: Prince George

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 25 Thurston Drive

10f. Zip Code: 20774

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): ; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Operating Room Tech.

16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*: Clyde M. Bennett

18. Mother's Name *(First, Middle, Maiden Surname)*: Jeanette Swann

19a. Informant's Name/Relationship *(Type, Print)*: Alphonso Slater (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25 Thurston Dr., Upper Marlboro, Md. 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: 1-16-01

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Billy Bell

22. Name and Address of Facility: Lewis Funeral Home, 311 N. Patrick St., Alex., Va. 22314

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Small cell Cancer of the lung — 17 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. Hawkins

29c. License number: DC MD 19757

29d. Date signed *(Month, Day, Year)*: 1/16/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Michael J. Hawkins, MD, 110 Irving Street N.W. Washington, D.C. 20010

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: Bonnie D. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02909

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE SMITH, SR.

2. Data of Death (Month, Day, Year): JANUARY 15, 2001

3. Time of Death: 4:30 PM

4a. Facility Name (If not institution, give street and number): 8313 Spruce Hill Drive

4b. City, Town, or Location of Death: Laurel

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 220-42-3229

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 54 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 28, 1946

9. Birthpiece (State or Foreign Country): Wash. DC

Usual Residence of Decedent

10a. Stata: MD

10b. County: Prince Geo.

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 8313 Spruce Hill Drive

10f. Zip Code: 20707

10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired): Produce Clerk

16b. Kind of Business/Industry: Giant Foods

17. Father's Neme (First, Middle, Last): Robert Clark

18. Mother's Name (First, Middle, Maiden Surneme): Geneva Smith

19a. Informent's Neme/Reletionship (Type, Print): Juanita Smith (Wife)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 8313 Spruce Hill Dr., Laurel, MD 20707

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Md. Nat'l Mem. Park

Dete: 1/20/01

20c. Location - City or Town, Stete: Laurel, MD

21. Signature of Funerel Servica Licensee: George R. Snowden SR

22. Neme end Address of Feciiity: SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feiiure. List only one ceuse on each line.

Approximete Interval Between Onset and Death

Immediete Cause (Finet disaase or condition resulting in death)

a. Liver Failure — 2 months

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseesa or injury that initiated events resulting in deeth) Last

b. Metastatic Carcinoma — 24 months

Due to (or es e consequence of):

c.

Due to (or es a consequanca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yaa 2☐No 3☐Probably 4☒Unknown

24a. Wes an eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medicat examiner? 1☐Yes 2☒No

26. Place of Deeth (Check only one) — Hospitei: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and manner as stated. 2☐Medical Examiner: On the besis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Marcia L Will MD

29c. License number: D35176

29d. Dete signed (Month, Day, Year): 1-17-01

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Marcia L. Will, M.D. 7525 Greenway Center, Dr., Greenbelt, MD 20770

State Registrar

31. Data filed (Month, Dey, Year): JAN 18 2001

32. Registrer's Signeture: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02910

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ZERALINE ULMAR SCHOOLS

2. Date of Death Month / Day / Year: January 14, 2001

3. Time of Death: 2:54 AM

4a. Facility Name *(If not institution, give street and number)*: Doctor's Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-44-7482

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 15, 1933

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: D.C.

10b. County: None

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1135 C Street, N.E.

10f. Zip Code: 20002

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse Assistant

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Julius Schools

18. Mother's Name *(First, Middle, Maiden Surname)*: Matilda Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Aralessa Stewart/Niece

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5719 Jost Street Fairmount Heights, MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Lincoln Memorial Cem — Date: 1/20/01

20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: D. Snyder

22. Name and Address of Facility: Henry S. Washington & Sons Co., Inc., 4925 N.H. Burroughs Ave., N.E. Washington, DC 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Hypotension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Metastatic cancer

Due to (or as a consequence of):

d. Respiratory failure

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

poor General health

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture end title of certifier: Mehrdad Sondegar MD

29c. License number: D050514

29d. Date signed *(Month, Day, Year)*: 1/15/01

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): MEHRDAD SONDEGAR, MD, 6570 Kenilworth Ave. Suite 210 Riverdale, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: D. Sparks

20337

DHMH 16 Rev 6/95

ORIGINAL

Zeraline Ulmar SCHOOLS

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02911

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNA HOLOWKO SCHUMEYKO

2. Date of Death — Month: 1 Day: 22 Year: 01

3. Time of Death: 1817

4a. Facility Name *(If not institution, give street and number)*: Snow Hill Nursing and Rehabilitation Center

4b. City, Town, or Location of Death: Snow Hill

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 220-28-4886

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8/19/1923

9. Birthplace *(State or Foreign Country)*: Ukraine

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5436 Pine St.

10f. Zip Code: 21863

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 6 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working lifa. DO NOT use retired)*: Poultry Grower

16b. Kind of Businass/Industry: Farming

17. Fathar's Nama *(First, Middla, Last)*: Konstantyn Holowko

18. Mother's Nama *(First, Middla, Maiden Surname)*: Maria Shiwtsowa

19a. Informant's Name/Relationship *(Type, Print)*: Tony Schumeyko/ Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 5831 Evergreen Terrace Snow Hill, MD 21863

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Sunset Memorial Park

Date: 1/25/01

20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: W. Fitch Burbage

22. Nama and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

To Be Completed by Funeral Director

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceusad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediata Ceuse (Final disaasa or condition rasulting in daath)

a. Respiratory Failure

Due to (or as a consequence of):

b. Ca. lung

Sequentially list conditions, if any, leading to immediata causa. Entar Underlying Cause (Disaase or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examinar? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Rasidance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, daath occurred at tha tima, date and place, and due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier: Baral

29c. License number: D54422

29d. Date signed *(Month, Day, Year)*: 1/23/01

30. Nama and address of parson who completed cause of daath (Item 23a) (Type, Print): Sarad Baral PO Box 25 Pocomoke City, MD 21851

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State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2001 02912

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BARBRA DENISE SY
2. Date of Death Month: January Day: 20 Year: 2001
3. Time of Death: 1258
4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 217-41-6587
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 20 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 3/15/1980
9. Birthplace *(State or Foreign Country)*: Philippines

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Ocean Pines
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 20 Rockside RD
10f. Zip Code: 21811
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Filipino

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Student
16b. Kind of Business/Industry: College

17. Father's Name *(First, Middle, Last)*: Henry Sy
18. Mother's Name *(First, Middle, Maiden Surname)*: Thelma Santa Cruz

19a. Informant's Name/Relationship *(Type, Print)*: Thelma Ward/ Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 20 Rockside RD Ocean Pines, MD 21811

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cape Henlopen Crematory
Date: 1/23/01
20c. Location - City or Town, State: Frankford, DE

21. Signature of Funeral Service Licensee: ▶ W. Eric Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Septic shock — 36 d

Due to (or as a consequence of):
b. Pneumonia — 48 d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ John McLean
29c. License number: D25209
29d. Date signed *(Month, Day, Year)*: 1/21/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John McLean 135 South Division Street Sby. MD 21804

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001
32. Registrar's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Barbra Sy 217-41-6587

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02913

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY CONSTANCE SCOTT

2. Date of Death (Month, Day, Year): JANUARY 17, 2001

3. Time of Death: 2:07 PM

4a. Facility Name (If not institution, give street and number): 7505 TITLEIST DRIVE

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMIOC

Funeral Director

5. Social Security Number: 165-10-2876

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 8, 1910

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7505 TITLEIST DRIVE

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ACCOUNTANT

16b. Kind of Business/Industry: THEATRE

17. Father's Name (First, Middle, Last): JOHN NARKWICZ

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Interment's Name/Relationship (Type, Print): MARY GLASGOW - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7505 TITLEIST DRIVE SALISBURY, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. PETER & PAUL CEMETERY

Date: 1/27/01

20c. Location - City or Town, State: SPRINGFIELD, PA.

21. Signature of Funeral Service Licensee: Melissa Kay Hess

22. Name and Address of Facility: 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. RHEUMATOID ARTHRITIS — >10YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald P. Trivitt

29c. License number: D36576

29d. Date signed (Month, Day, Year): 1/28/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RONALD P. TRIVITT MD 560 Riverside Dr SALISBURY MD 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Penny D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0222-047

GORDON
SELLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02914

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GORDON K. SELLS
2. Date of Death Month / Day / Year: JANUARY 13, 2001
3. Time of Death: 11:30A.M.
4a. Facility Name *(If not institution, give street and number)*: SCOTTY ROAD NORTH OF OAK HALL ROAD
4b. City, Town, or Location of Death: SNOW HILL
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 218-74-3395
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 37 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12-30-63
9. Birthplace *(State or Foreign Country)*: DE.

Usual Residence of Decedent

10a. State: MD.
10b. County: WICOMICO
10c. City, Town or Location: TYASKIN
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4356 TYASKIN RD.
10f. Zip Code: 21865
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: AIR FORCE
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ENGINEER OF PRODUCTION
16b. Kind of Business/Industry: FILTRONIC COMTEK

17. Father's Name *(First, Middle, Last)*: JACOB SELLS
18. Mother's Name *(First, Middle, Maiden Surname)*: GLADYS MAXFELD SELLS

19a. Informant's Name/Relationship *(Type, Print)*: WIFE BARTHINE HULL SELLS
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4356-TYASKIN RD. TYASKIN, MD. 21865

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: DOVER CREMATORY — Date: 1/22/01
20c. Location - City or Town, State: DOVER, DELAWARE

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: BENNIE SMITH F/H 917 W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Contact Gunshot Wound of Head
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 1-13-1
28b. Time of Injury: 11:30 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: subject shot self
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: woods
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Scotty Road

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: JANUARY 14, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: Penny G. Sparks

8th VA DQ

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

RKD

01-0223-047

BRANDI SELLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02915

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BRANDI N. SELLS

2. Date of Death Month: JANUARY Day: 13, Year: 2001

3. Time of Death: 11:30A.M.

4a. Facility Name (If not institution, give street end number): SCOTTY ROAD NORTH OF OAK HALL ROAD

4b. City, Town, or Location of Death: SNOW HILL

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 217-08-1741

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 16 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3-8-84

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. 10b. County: WICOMICO 10c. City, Town or Location: TYASKIN 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4356-TYASKIN RD. 10f. Zip Code: 21865 10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: DAWN DANCE STUDIO

17. Father's Name (First, Middle, Last): HOWARD LANIER

18. Mother's Name (First, Middle, Maiden Surname): BARTHINE HULL SELLS

19a. Informant's Name/Relationship (Type, Print): MOTHER BARTHINE HULL SELLS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4356 TYASKIN RD, TYASKIN, MD. 21865

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FAMILY PRIVATE CEMETARY Date: 1/20/2001

20c. Location - City or Town, State: TYASKIN MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: BENNIE SMITH FH 917-W. ISABELLA ST. SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Gunshot Wound of Head

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) SCENE

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☒ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 1-13-1 28b. Time of Injury: 11 30 AM 28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Suspect Shot

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Woods

28f. Location (Street and Number or Rural Route Number, City or Town, State): Scotty Road

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): JANUARY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: [signature] B. Sparks

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5 DQ

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02916

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Laura Fenrich Struve

2. Date of Death Month / Day / Year: January 19, 2001

3. Time of Death: 6:10 PM

4a. Facility Name *(If not institution, give street and number)*: 503 Ponderosa Drive

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-26-2783

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr. 4, 1931

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 503 Ponderosa Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Godfrey (nmn) Fenrich

18. Mother's Name *(First, Middle, Maiden Surname)*: Elsie May Klapp

19a. Informant's Name/Relationship *(Type, Print)*: John R. Struve- Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 503 Ponderosa Drive, Bel Air, Maryland 21014

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Hilltop Service Corp. | Date: 1/24/01

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Holly McComas Benning Jr

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. METASTATIC BREAST CANCER	2 YRS
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ricardo Spira MD

29c. License number: D55860

29d. Date signed *(Month, Day, Year)*: Jan 20, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A Spira MD, Johns Hopkins Hospital, Baltimore MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 2001

32. Registrar's Signature: D. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02917

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Connie Lee Schools	January 15, 2001	3:03 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4437 Kendi Road	Baltimore	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-28-3164	1☐ M 2☒ F	70 Yrs.			Dec. 28, 1930	Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
4437 Kendi Road	21236	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th Grade		Keypunch Operator	Petroleum Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank DeFalco	Angelina Yfrate

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mr. Ralph F. Schools (husband)	4437 Kendi Road, Baltimore, MD 21236

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Entombment	Holly Hill Mausoleum	1/17/01	Baltimore, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Amanda Kelly	Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. STROKE	Hours
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hypertension	Years
Due to (or as a consequence of):		
	c. DIABETES Mellitus Type 2	Years
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D0053536	1/16/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL GOLDSMITH, MD 1321 RIVERSIDE PKWY SEL CAMP, MD 21017

State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature
	JAN 17 2001	[signature] N. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02918

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): PERCY JAMES SHORTALL SR.
2. Dete of Death: Month Jan Day 12 Year 2001
3. Time of Death: 1:29 PM
4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 217-36-0969
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 19,1907
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Talbot
10c. City, Town or Location: Easton
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10 Magnolia St.
10f. Zip Code: 21601
10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Farmer
16b. Kind of Business/Industry: Farming

17. Father's Neme (First, Middle, Last): William J. Shortall
18. Mother's Neme (First, Middle, Maiden Sumame): Maude Ethel Andrews

19a. Informant's Neme/Reletionship (Type, Print): Elizabeth J. May Daughter
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 12515 Gramlich Rd. LaVale, Md. 21502

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Placa of Disposition (Neme of cametery, crematory or other piece): Spring Hill Cemetery
Dete: Jan. 15,2001
20c. Location - City or Town, Stete: Easton, Maryland

21. Signeture of Funeral Service Licensee: Harrison E. Leonard
22. Name end Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21601

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. cardiomyopathy — months
Due to (or as a consequence of):
b. ischemic heart disease — years
Due to (or es a consequence of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest
c. arteriosclerosis — years
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic obstructive lung disease atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [✓] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner steted.

29b. Signeture and title of certifier: MD
29c. License number: D25750
29d. Date signed (Month, Dey, Year): 1/12/01

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT SANCHEZ, MD 508 IDLEWILD AVENUE EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrer's Signature: Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Percy Shortall
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

SBB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02919

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERTA A. SEWELL
2. Date of Death: Month JAN. Day 13 Year 2001
3. Time of Death: 1405
4a. Facility Name (If not institution, give street and number): 5825 OLD TRAPPE ROAD
4b. City, Town, or Location of Death: TRAPPE
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 220-28-0027
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 30, 1933
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: TRAPPE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5825 OLD TRAPPE ROAD
10f. Zip Code: 21673
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): -0-
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): ROBERT J. SINCLAIR
18. Mother's Name (First, Middle, Maiden Surname): GRACE HUGHES

19a. Informant's Name/Relationship (Type, Print): CLARKE W. SEWELL, JR./HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5825 OLD TRAPPE ROAD, TRAPPE, MD 21673

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN MEMORIAL PARK
Date: 1-16-2001
20c. Location - City or Town, State: EASTON, MD

21. Signature of Funeral Service Licensee: ▶ M. L. Newnam III C.F.S.P.
22. Name and Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	METASTASES LIVER, BRAIN & BONE	14 DAYS
Due to (or as a consequence of): b.	ADENOCARCINOMA COLON	14 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: NONE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ C. W. Bain MD
29c. License number: D0000250
29d. Date signed (Month, Day, Year): 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. BAIN, 609 DUTCHMANS LANE, EASTON, MD, 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: ▶ Geneva G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

SAB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02920

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE Y. SMITH

2. Date of Death (Month, Day, Year): JANUARY 11, 2001

3. Time of Death: 7:45PM

4a. Facility Name (If not institution, give street and number): SPRINGBROOK NURSING & REHAB CENTER

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 149-09-5305

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): 105 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JULY 26,1895

9. Birthplace (State or Foreign Country): GEORGIA

Usual Residence of Decedent

10a. State: NJ

10b. County: CAMDEN

10c. City, Town or Location: CAMDEN

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 418 BENSON STREET

10f. Zip Code: 08103

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7TH | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC

16b. Kind of Business/Industry: HOME

17. Father's Name (First, Middle, Last): WILLIAM CLARK

18. Mother's Name (First, Middle, Maiden Surname): REBECCA STREET

19a. Informant's Name/Relationship (Type, Print): ANDREW M. YOUNG (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 HAMILTON AVE. SILVER SPRING, MD 20901

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FLIPPEN FUNERAL HOME

Date: 01/13/01

20c. Location - City or Town, State: CAMDEN, NJ

21. Signature of Funeral Service License: George R. Snowden Jr

22. Name and Address of Facility: SNOWDEN FUNERAL HOME 246 N. WASH ST. ROCKVILLE, MD 20850

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Dementia of Alzheimers Type — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D42403

29d. Date signed (Month, Day, Year): 1/16/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJ MATHUR 106 Irving Street NW Washington DC 20010

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02921

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roland Jesse Swann, Sr.

2. Date of Death (Month, Day, Year): January 20, 2001

3. Time of Death: 4:20 PM

4a. Facility Nsme *(If not institution, give street and number)*: 37685 Frischholoz Court

4b. City, Town, or Location of Death: Mechanicsville

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 219-05-8897

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthdey)*: 80 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dsy, Year)*: June 25, 1920

9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Charles

10c. City, Town or Location: White Plains

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4727 Hickory Court

10f. Zip Code: 20695

10g. Citizen of What Country?: U S A

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 42-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 10th grade; College (1-4or 5+):

16a. Decedent's Ususl Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner & Operator

16b. Kind of Business/Industry: Automobile Dealership

17. Fether's Name *(First, Middle, Last)*: Richard Jesse Swann

18. Mother's Name *(First, Middle, Meiden Surname)*: Effie Margaret Latimer

19a. Intormant's Name/Relationship *(Type, Print)*: Roland J. Swann, Jr. (Son)

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stste, Zip Code)*: 926 Sloan Avenue, Waldorf, Maryland 20602

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Plece of Disposition *(Name of cemetery, crematory or other plsce)*: Maryland Veterans

Date: 1/25/01

20c. Location - City or Town, Stste: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, JR M00052

22. Name and Address of Facility: Brinsfield/Echols Funeral Home, P.A. P.O. Box 128, Charlotte Hall, Maryland 20622

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory arrest, shock, or heert tailure. List only one cause on eech line.

Approximate Interval Between Onset end Desth

Immediate Cause (Final disease or condition resulting in deeth)

a. Carcinomatosis — Months

Due to (or as s consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Prostate Cancer — Years

Due to (or es a consequence ot):

c.

Due to (or as s consequence ot):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24s. Was sn sutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings svsilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Plece ot Desth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)*: Daughter's Residence

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Jarboe, MD

29c. License number: D06419

29d. Date signed *(Month, Day, Year)*: 1-23-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James P. Jarboe, MD Hollywood, Maryland 20636

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 25 2001

32. Registrar's Signature: S. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02922

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Louise Sullivan
2. Date of Death (Month, Day, Year): January 20, 2001
3. Time of Death: 12:01 AM
4a. Facility Name (If not institution, give street and number): 38610 Pleasant Harbor Way
4b. City, Town, or Location of Death: Abell
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-52-5700
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 24, 1911
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Abell
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 38610 Pleasant Harbor Way
10f. Zip Code: 20606
10g. Citizen of What Country?: U S A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William Ford Nelson
18. Mother's Name (First, Middle, Maiden Surname): Ella I. Bowles

19a. Informant's Name/Relationship (Type, Print): DAvid J. Sullivan (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 N. Rainbow Lake Road, Wichita, Kansas 67235

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Queen of Peace Cemetery
Date: 1/23/01
20c. Location - City or Town, State: Helen, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Congestive Heart failure	6 mnths
Due to (or as a consequence of): b.	Coronary Artery disease	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D33470
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Bhasker Jhaveri, MD Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature:

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JAN 2 5 2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02923

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gladys Ruth Stein

2. Date of Death (Month, Day, Year): January 17, 2001

3. Time of Death: 8:47 P.M.

4a. Facility Name (If not institution, give street and number): 45885 Meadow Lark Drive

4b. City, Town, or Location of Death: Great Mills

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 213-20-2739

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 23, 1924

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Great Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 45885 Meadow Lark Drive

10f. Zip Code: 20634

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker

16b. Kind of Business/Industry: At home

17. Father's Name (First, Middle, Last): Arthur Andreas Larsen

18. Mother's Name (First, Middle, Maiden Surname): Karla Marie Sofie Mortensen

19a. Informant's Name/Relationship (Type, Print): Susan M. Holmes Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 45885 Meadow Lark Drive, Great Mills, Maryland 20634

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Charles Memorial Gardens

Date: January 20, 2001

20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. 000052

22. Name and Address of Facility: Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinomatosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. hepatobiliary cancer — 1 yr.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Patrick Jarboe, M.D.

29c. License number: D0619

29d. Date signed (Month, Day, Year): 1-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Patrick Jarboe, M.D. Hollywood, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02924

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ellen Imogene STEWART

2. Date of Death: Month January Day 20 Year 2001

3. Time of Death: 16:52

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 214-30-3334

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 28 1922

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9938 Crystal Falls Drive

10f. Zip Code: 21740

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Okel Kermin McCallister

18. Mother's Name (First, Middle, Maiden Surname): Lillie Charlotte Watson

19a. Informant's Name/Relationship (Type, Print): James Stewart - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21733 Mt. Aetna Road Hagerstown, Maryland 21742

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery

Date: 1/25/01

20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Fred L. Vestal

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. acute myocardial Infarction

Due to (or as a consequence of): Chronic Congestive heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of): Insulin dependent diabetes mellitus

c. Due to (or as a consequence of): Chronic renal failure

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: obesity

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rapurao Pulivarti, MD

29c. License number: D20233

29d. Date signed (Month, Day, Year): 1/21/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): BAPURAO PULIVARTI, MD 12931 Oakhill Ave, Hagerstown MD 21742

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001

32. Registrar's Signature: Donna D Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Stewart, Ellen Imogene

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02925

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVERETT LEON SANBORN

2. Date of Death Month: January Day: 29 Year: 2001

3. Time of Death: 17:16

4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital

4b. City, Town, or Location of Death: Prince Frederick

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 009 10 8927

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 26, 1924

9. Birthplace *(State or Foreign Country)*: Maine

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Dunkirk

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3528 King Drive

10f. Zip Code: 20754

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-63

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: tractor service/repairman

16b. Kind of Business/Industry: retail dept. store

17. Father's Name *(First, Middle, Last)*: Everett Sanborn

18. Mother's Name *(First, Middle, Maiden Surname)*: Eva Charon

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Bernyce E. Sanborn, spouse

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as # 10 a-f above

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MD Veterans Cemetery

Date: 02-05-01

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ William R. [illegible]

22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 2 WEEKS

Due to (or as a consequence of):

b. HYPERTENSIVE HEART DISEASE — SEVERAL YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE LUNG DISEASE

MASS RIGHT LUNG.

CARCINOMA OF PROSTATE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A T Munshi, MD Attending physician

29c. License number: D 19427.

29d. Date signed *(Month, Day, Year)*: 1-30-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANWAR T. MUNSHI M.D. PRINCE FREDERICK, MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 31 2001

32. Registrar's Signature: ▶ Debra G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02926

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ARTHUR CLEVELAND SMITH
2. Data of Death Month Day Year: JANUARY 22,2001
3. Time of Death: 1848
4a Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Pr. Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 213-62-9667
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)* Yrs.: 46
If Under 1 Year Months / Days:
If Under 24 Hrs. Hours / Min.:
8. Dete of Birth *(Month, Day, Year)*: AUG. 17,1954
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedant

10a. Steta: MD
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 142 German Chapel Road
10f. Zip Code: 20678
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Raca - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondery (0-12): 9; Collega (1-4or 5+):
18a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: Carpet Cleaner
16b. Kind of Busines/Industry: Carpet Care

17. Fethar's Name *(First, Middle, Last)*: Arthur Smith, Sr.
18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Beatrice Whitcomb

19a. Informant's Name/Retetionship *(Type, Print)*: Dana Harmon/Daughter
19b. Meiling Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 3212 Polar Ave., Baltimore, MD 21227

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Steta 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cematary, cramatory or other place)*: All Saints Episcopal
Deta: 1/27/01
20c. Location - City or Town, Stata: Reisterstown, MD

21. Signetura of Funaral Service Licensee: Gerry Wood
22. Name end Address of Facility: Raymond-Wood F.H., P.A. P.O. Box 430, Dunkirk, MD 20754

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, of complications that ceused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or heart feilura. List only ona cause on aach line.

Approximate Intarval Between Onset end Deeth

Immediate Cause (Finel disaasa or condition resulting in death)
a. Chronic obstructive Lung Disease
Due to (or as e consequenca of):
b. Respiratory Acidosis
Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiated evants resulting in death) Last
Due to (or as a consequenca of):
c. Tobacco Abuse
Due to (or as e consequence of):
d. Uncontrolled hypertension

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: Alcohol Abuse

23b. Did tobacco use contribute to the cauee of death? 1 [X] Yee 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No
24b. Ware autopsy findings available prior to comptation of ceusa of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No
26. Place of Deeth *(Check only ona)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Rasidanca 6 [ ] Othar *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding Investigetion 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, daath occurred at tha tima, data and place, end dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination end/or Investigation, in my opinion, daath occurred at the tima, data and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Bees MD
29c. License number: D0052097
29d. Date signed *(Month, Day, Year)*: 1/23/2001

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): DR. JANELLE BELL,MD PRINCE FREDERICK,MD 20678

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signatura: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02927

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sadie Ellen Stallings
2. Date of Death (Month, Day, Year): January 19, 2001
3. Time of Death: 4:00 p.m.
4a. Facility Name (If not institution, give street and number): 3818 26th Street
4b. City, Town, or Location of Death: Chesapeake Beach
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 212 62 2008
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 16, 1919
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Chesapeake Beach
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 3818 26th Street
10f. Zip Code: 20732
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker
16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Morris Edward Stallings
18. Mother's Name (First, Middle, Maiden Surname): Mollie L Ward

19a. Informant's Name/Relationship (Type, Print): Clara Mae Buckmaster, daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as # 10 a-f above

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Southern Mem. Gardens
Date: 01-23-01
20c. Location - City or Town, State: Dunkirk, MD

21. Signature of Funeral Service Licensee: William R. Jr
22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Respiratory Failure
Due to (or as a consequence of):
b. Chronic Obstructive Pulmonary Disease
Due to (or as a consequence of):
c. and Cor Pulmonale
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D33123
29d. Date signed (Month, Day, Year): 1-22-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jonathan Lowenthal, M.D. Prince Frederick, MD 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 24 2001
32. Registrar's Signature: Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02928

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ADA ROSE SMITH

2. Date of Death: Month January Day 18 Year 2001

3. Time of Death: 8:28 a.m.

4a. Facility Name (If not institution, give street and number): 7811 DeForest Drive

4b. City, Town, or Location of Death: Chesapeake Beach

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 226 24 9767

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 27, 1922

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Chesapeake Beach

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7811 DeForest Drive

10f. Zip Code: 20732

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Charlie Mason Dalton

18. Mother's Name (First, Middle, Maiden Surname): Myrtle Vasser

19a. Informant's Name/Relationship (Type, Print): Jane Marie Robey, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as # 10 a-f

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 01-22-01

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: William R. [illegible]

22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature] MD

29c. License number: D29657

29d. Date signed (Month, Day, Year): 1/19/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles Judge, M.D., Prince Frederick, MD 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Geneva B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

5

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02929

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jeffrey Dwight Shaffer
2. Date of Death (Month, Day, Year): January 16 2001
3. Time of Death: 6:00 PM
4a. Facility Name (If not institution, give street and number): 12804 Greensboro Road
4b. City, Town, or Location of Death: Greensboro
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 219-70-7884
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 40 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): March 16, 1960
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Greensboro
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 12804 Greensboro Road
10f. Zip Code: 21639
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): welder
16b. Kind of Business/Industry: industrial

17. Father's Name (First, Middle, Last): George Shaffer
18. Mother's Name (First, Middle, Maiden Surname): Ennis Childress

19a. Informant's Name/Relationship (Type, Print): Patti Shaffer spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12804 Greensboro Ro Greensboro, Maryland 21639

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greensboro Cemetery
Date: Jan 20 2001
20c. Location - City or Town, State: Greensboro, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Fleegle - Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Adenocarcinoma of unknown primary — 1 month
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Julie R Brahmer MD
29c. License number: D0051770
29d. Date signed (Month, Day, Year): January 18 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Julie R. Brahmer MD 1650 Orleans Street, Baltimore, MD 21231-1000

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0177-033
mnmr
Milton T. Speight

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02930

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Milton T. Speight
2. Date of Death Month Day Year: January 10, 2001
3. Time of Death: 2320 pm
4a. Facility Name *(If not institution, give street and number)*: 1208 Sue Lane
4b. City, Town, or Location of Death: Capitol Heights
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 246-40-4243
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2/12/32
9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: Md.
10b. County: P.G.
10c. City, Town or Location: Capitol Hgts.
10d. Inside City Limits: 1☒ Yes 2☐ No
10a. Street and Number: 1208 Sue Lane
10f. Zip Code: 20743
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: '53-'55
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4 Yrs.
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer
16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Milton Blount
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes Speight

19a. Informant's Neme/Relationship *(Type, Print)*: Deborah Speight/Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 3216 Amador Dr.,Hyattsville,Md. 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cem.
Date: 1/19/01
20c. Location - City or Town, Stata: Cheltenham, Md.

21. Signature of Funeral Service Licensee: ▶ Larry W. Pratt
22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.,Wash.,D.C. 20019

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)
a. Pericardial Tamponade
Due to (or as s consequenca of):
b. Aortic Dissection
Due to (or as a consequenca of):
c.
Dua to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* at scene
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signatura and title of certifier: ▶ Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: January 11, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: ▶ Barbara G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

(15)

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02931

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Florence Seymore

2. Date of Death — Month: January; Day: 17; Year: 2001

3. Time of Death: 5:50 A.M.

4a. Facility Name *(If not institution, give street and number)*: Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579 40 7969

6. Sex: 1☐ M 2☐ F XX

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year — Months: ; Days: ; If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Jan 26, 1933

9. Birthplace *(State or Foreign Country)*: Washington DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 40154 Waterview Drive

10f. Zip Code: 20659

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced XX

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 1

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Melvin John Griggs, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Florence Louise Childs

19a. Informant's Name/Relationship *(Type, Print)*: Gary B. Griggs (NEPHEW)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9601 Marlboro Pike , Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: Jan 20, 2001

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Stu G. Lith

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Severe Anemia

Due to (or as a consequence of):
b. Bone Marrow Depression

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Metastatic Lung Cancer

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Spinal Cord Compression

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ [signature] MD

29c. License number: D0053219

29d. Date signed *(Month, Day, Year)*: 1·18·2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ZAFAR A. ANSARI, MD 7E POST OFFICE RD, WALDORF, MD 20602

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001

32. Registrar's Signature: ▶ [signature] S. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02932

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myra Wesley Slacum

2. Date of Death — Month: January Day: 22 Year: 2001

3. Time of Death: 450

4a. Facility Name (If not institution, give street and number): Dorchester General Hospital

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 214-07-7056

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 12, 1919

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 314 Crusader Rd. #201

10f. Zip Code: 21613

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): seamstress

16b. Kind of Business/Industry: shirt factory

17. Fether's Neme (First, Middle, Last): Robert Bain Hall

18. Mother's Neme (First, Middle, Maiden Sumame): Lola May Hinton

19e. Informent's Neme/Reletionship (Type, Print): Barbara Marsh - daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 432 Aurora St., Cambridge, MD 21613

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Salisbury Cremetory — Dete: 1-23

20c. Location - City or Town, Stete: Salisbury, Maryland

21. Signeture of Funeral Service Licensee: ▶ [signature]

22. Name end Address of Fecility: Thomas Funeral Home PA, 700 Locust St., Cambridge, MD 21613

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in death): e. Metastatic Mesothelioma — 24 Days

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evailable prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the cause(s) and menner as stated. 2☐ **Medical Examiner**: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end ptece, end due to the cause(s) end manner steted.

29b. Signeture end title of certifier: ▶ William Bair

29c. License number: 043238

29d. Date signed (Month, Day, Year): January 22, 2001

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): William Bair 19 Franklin St. Cambridge, MD 21613

State Registrar

31. Dete filed (Month, Day, Year): JAN 22 2001

32. Registrer's Signeture: ▶ Donna G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

01-0195-033
TROY G. THOMAS
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02933

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TROY G. THOMAS
2. Date of Death (Month, Day, Year): JANUARY 11 2001
3. Time of Death: 2127
4a. Facility Name (If not institution, give street and number): PRINCE GEORGE HOSPITAL
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 215-06-5712
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 30 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 09-25-1970
9. Birthplace (State or Foreign Country): D.C.

Usual Residence of Decedent

10a. State: Md.
10b. County: Prince George's
10c. City, Town or Location: Suitland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3906 Regency Parkway
10f. Zip Code: 20746
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12th Grade
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager
16b. Kind of Business/Industry: McDonald's

17. Father's Name (First, Middle, Last): Tyrone G. Berry
18. Mother's Name (First, Middle, Maiden Surname): Lula Thomas

19a. Informant's Name/Relationship (Type, Print): Mary A. Wright (Grand-Mother)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): T-2 3906 Regency Parkway Suitland, Md. 20746

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery
Date: 1-10-2001
20c. Location - City or Town, State: Washington, D.C

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Columbia Heights Funeral 3605 14th Street, N.W. Washington, D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 20010

Immediate Cause (Final disease or condition resulting in death):
a. Gunshot Wound of Back of Chest
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): 1/11/01
28b. Time of Injury: 2039 M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Subject Shot
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): 4342 Barker LN SE WASH. DC

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): JANUARY 12, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Alton Locke MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM 23a per ME G794 040201 SS

Certificate of Death

Reg. No. 2001 02934

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Celeta S. Tillery

2. Date of Death: Month January Day 13 Year 2001

3. Time of Death: 03:22 A.M.

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 280-40-0301

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 03-22-1944

9. Birthplace (State or Foreign Country): Middletown, OH

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Glenarden

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7932 Cawker Ave

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 2yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer system Analyst

16b. Kind of Business/Industry: Government

17. Father's Name (First, Middle, Last): Monroe Vernon Smith

18. Mother's Name (First, Middle, Maiden Surname): James Laverne Stallworth

19a. Informant's Name/Relationship (Type, Print): Loretta Tillery/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7932 Cawker Ave Glenarden, MD 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Woodside Cemetery

Date: 1-17-01

20c. Location - City or Town, State: Middletown, Ohio

21. Signature of Funeral Service Licensee ▶

22. Name and Address of Facility: J.B. Jenkins Funeral Home 7474 Landover Rd Landover, MD 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. SARCOIDOSIS COMPLICATED BY HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier ▶

29c. License number: O.C.M.E

29d. Dete signed (Month, Day, Year): JANUARY 16,2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARY C. RIPPLE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature ▶ Bernice G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02935

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mabel Todd

2. Date of Death Month / Day / Year: January 10, 2001

3. Time of Death: 2:45 am

4a. Facility Name *(If not institution, give street and number)*: National Lutheran Home

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 156-30-6641

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Apr 2, 1912

9. Birthplace *(State or Foreign Country)*: New Hampshire

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14317 Sturtevant Road

10f. Zip Code: 20905

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse

16b. Kind of Business/Industry: Medical

17. Father's Name *(First, Middle, Last)*: Charles Flanders

18. Mother's Name *(First, Middle, Maiden Surname)*: Emily Kendall

19a. Informant's Name/Relationship *(Type, Print)*: Emily T. Slunt/ Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14317 Sturtevant Road, Silver Spring, MD 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Whiting Memorial Park — Date: Jan 18 2001

20c. Location - City or Town, State: Whiting, NJ

21. Signature of Funeral Service Licensee: ▶ William J Byl

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Acute Cerebrovascular Accident	4 weeks
Due to (or as a consequence of): b.	Aspiration pneumonia	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Charles W. Karesh MD

29c. License number: D21726

29d. Date signed *(Month, Day, Year)*: January 10, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles W. Karesh, MD 26033 Ridge Road, Damascus, MD 20872

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001

32. Registrar's Signature: ▶ pening G. Sparks

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02936

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert Thomas

2. Date of Death Month / Day / Year: January 17, 2001

3. Time of Death: 6:30 AM

4a. Facility Name *(If not institution, give street and number)*: 2015 Ruffs Mill Road

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-30-1354

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 6, 1934

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2015 Ruffs Mill Road

10f. Zip Code: 21015

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Korea 1962

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Construction

16b. Kind of Business/Industry: Road Construction

17. Father's Name *(First, Middle, Last)*: John William Thomas

18. Mother's Name *(First, Middle, Maiden Surname)*: Gladys (NMN) Hilton

19a. Informant's Name/Relationship *(Type, Print)*: Betty J. Thomas/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2015 Ruffs Mill Road, Bel Air, MD 21015

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens | Date: 1/20/01

20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: Charles A. Emge II

22. Name and Address of Facility: McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset snd Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic small cell carcinoma of lung — 2 months

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest

b. Due to (or as e consequanca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] **Yes** 2 [ ] **No** 3 [ ] **Probably** 4 [X] **Unknown**

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to *medical examiner*? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and *manner* as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and *manner* stated.

29b. Signature and title of certifier: C Eck MD

29c. License number: D31712

29d. Date signed *(Month, Day, Year)*: 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES ECK JR 219 W. BEL AIR AVE. ABERDEEN, MD 21001

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 18 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02937

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EMILY FLETCHER TARPLEY
2. Date of Death (Month, Day, Year): JANUARY 13, 2001
3. Time of Death: 11:00
4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 215-36-4971
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 15, 1938
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Churchton
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1262 Chesapeake Drive
10f. Zip Code: 20733
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indien, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher
16b. Kind of Business/Industry: Prince George's County Public Schools
17. Father's Name *(First, Middle, Last)*: John Raymond Fletcher
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Emma Frances Hall
19a. Informant's Name/Relationship *(Type, Print)*: John S. Tarpley - Son
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 1262 Chesapeake Drive, Churchton, MD 20733
20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other pieca)*: Fort Lincoln Cemetery — Date: 01/20/01
20c. Location - City or Town, State: Brentwood, Maryland
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. CIRRHOSIS OF LIVER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest
b.

Due to (or as a consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an eutopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Meener of Deeth: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D-25935
29d. Dete signed *(Month, Day, Year)*: 1/15/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR.M.MATHUR 110 HOSPITAL RD. PRINCE FREDERICK, MD. 20678

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 18 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

(10)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02938

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Thompson
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 11:57 a.m.
4a. Facility Name (If not institution, give street and number): 16444 Ball Point Road
4b. City, Town, or Location of Death: Piney Point
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 229-16-9272
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7.10.1922
9. Birthplace (State or Foreign Country): Washington,DC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Piney Point
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 16444 Ball Point Road
10f. Zip Code: 20674
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician
16b. Kind of Business/Industry: Electrical

17. Father's Name (First, Middle, Last): Mulry J. Thompson
18. Mother's Name (First, Middle, Maiden Surname): Ethel Mae Hern

19a. Informant's Name/Relationship (Type, Print): Mary Burke Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 932 S. 21st Street, Arlington, VA 22202

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): St. George Catholic Cemetery
Date: January 15, 2001
20c. Location - City or Town, State: Valley Lee,Maryland

21. Signature of Funeral Service Licensee: Edward N. Brinsfield, Jr. M00052
22. Name and Address of Facility: Brinsfield Funeral HOme, P.A., 22955 Hollywood Road, P.O. Box 279,Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SUDDEN CARDIAC DEATH	UNKNOWN
Due to (or as a consequence of):	b. CORONARY ARTERY DISEASE	YEARS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. ISCHEMIC CARDIOMYOPATHY	YEARS
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- SEVERE LEFT VENTRICULAR DYSFUNCTION
- DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? 1☐Yes 2☐No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anil K. Shah MD FACC
29c. License number: D 40593
29d. Date signed (Month, Day, Year): 1/12/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Shah, Anil K. Hollywood, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: B. Sparks

(10)

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02939

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrew Paul Toth

2. Date of Death Month Day Year: January 11, 2001

3. Time of Death: 12:50 AM

4a. Facility Name (If not institution, give street and number): 17275 Oakwood Lodge Lane

4b. City, Town, or Location of Death: Piney Point

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 579-10-4116

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 6,1914

9. Birthplace (State or Foreign Country): Pennyslvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Piney Point

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No X

10e. Street and Number: 17275 Oakwood Lodge Lane

10f. Zip Code: 20674

10g. Citizen of What Country?: U.S.A

11. Marital Status: XX 1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No X If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cook/ Bartender

16b. Kind of Business/Industry: Food Service

17. Father's Name (First, Middle, Last): Andrew Toth

18. Mother's Name (First, Middle, Maiden Surname): Barbara Undo

19a. Informant's Name/Relationship (Type, Print): Frank Toth/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 367 Piney Point MD. 20674

20a. Method of Disposition: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Data: 01/11/01

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Michael K Gardiner M00227-

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic prostate carcinoma — 6 Yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: severe COPD

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Komell MD

29c. License number: D36206

29d. Date signed (Month, Day, Year): 01/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kiran D. Mehta, MD Hollywood, Maryland 20636

State Registrar

31. Date filed (Month, Day, Year): JAN 12 2001

32. Registrar's Signature: Barbara B. Goode

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02940

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY THOMAS
2. Date of Death Month Day Year: JANUARY 24, 2001
3. Time of Death: 0600
4a. Facility Name *(If not institution, give street and number)*: Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 213-82-2373
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 14, 1937
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1705 Joe Harris Road
10f. Zip Code: 20678
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harold Wills
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Gray

19a. Informant's Name/Relationship *(Type, Print)*: Madie Harris/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1755 Joe Harris Road Prince Frederick, MD 20678

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Solid Rock Church Cem.
Date: 1/27/01
20c. Location - City or Town, State: Port Republic, MD

21. Signature of Funeral Service Licensee: ▶ Gladys A. Sewell
22. Name and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic lung cancer — 1 year
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Chronic renal Failure
non-insulin - dependent diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MV. M
29c. License number: 048714
29d. Date signed *(Month, Day, Year)*: 1/24/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL POMILLA, MD PRINCE FREDERICK, MD 20678

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 26 2001
32. Registrar's Signature: ▶ Emma G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

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To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02941

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE IRENE TUTTLE
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 1050
4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 201 12 3166
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 28, 1924
9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD
10b. County: Calvert
10c. City, Town or Location: Owings
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1030 Lord Cecil Drive
10f. Zip Code: 20736
10g. Citizen of What Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indien, Bleck, White, etc. Specify: white

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): secretary
16b. Kind of Business/Industry: publishing

17. Father's Neme (First, Middle, Last): Merle Spencer
18. Mother's Name (First, Middle, Maiden Surname): Mary Hawk

19a. Informent's Neme/Reletionship (Type, Print): Mary G. Young (daug.)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14878 Geranium Ct., Woodbridge, VA 22193

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, crematory or other piece): MD Veterans Cemetery
Dete: 1-26-01
20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funerel Service Licensee: ▶ [signature]
22. Neme end Address of Facility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Finel diseese or condition resulting in death) a.	Acute Myocardial Infarct	12 hours
Due to (or es a consequence of):		
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last b.	Sepsis	14 hours
Due to (or as e consequence of):		
c.		
Due to (or as e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner es stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner steted.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D45235
29d. Dete signed (Month, Day, Year): 1/21/01

30. Neme and address of parson who completed cause of deeth (Item 23a) (Type, Print): Catherine I. Brophy, MD 10845 Town Center Blvd. #203, Dunkirk, MD 20754

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 24 2001
32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ADH
RAYMOND THOMAS
01-0202-009

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02942

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Raymond Thomas
2. Date of Death Month Dey Year: JANUARY 12, 2001
3. Time of Death: 1735 PM
4a Facility Nema *(If not institution, give street and number)*: 4341 SIXES ROAD
4b. City, Town, or Location of Death: PRINCE FREDERICK
4c. County of Death: CALVERT

Funeral Director

5. Social Security Number: 214-30-0430
6. Sex: 1[X] M 2[ ] F
7. Age *(In yrs. last birthday)*: 69 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: Dec.16,1931
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Calvert
10c. City, Town or Location: Prince Frederick
10d. Inside City Limits: 1[ ] Yes 2[X] No
10a. Street and Number: 4341 Sixes Road
10f. Zip Code: 20678
10g. Citizen of What Country?: USA

11. Meritel Status: 1[X] Nevar Married 2[ ] Merried 3[ ] Widowed 4[ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1[X] Yas 2[ ] No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1[ ] Yes 2[X] No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: Black
15. Decedent's Educetion *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 6 / College (1-4or 5+):
16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Farmer
16b. Kind of Business/Industry: Farming
17. Father's Name *(First, Middle, Last)*: Clarence Thomas
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Annie C. Hawkins
19a. Informant's Name/Reletionship *(Type, Print)*: Isaac Thomas/Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. Box 1041 Chesapeake Beach, MD 20732
20a. Method of Disposition: 1[ ] Burial 2[X] Cremetion 3[ ] Removel from Stete 4[ ] Donetion 5[ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cramatory or othar piece)*: Metropolitan Crematory
Dete: 1/18/01
20c. Location - City or Town, Steta: Alexandria, VA
21. Signeture of Funerel Service Licensee: ▶ Gladys A. Sewell
22. Nama end Address of Fecility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused tha death. Do not enter the moda of dying, such as cardiac or raspiretory arrest, shock, or heert failure. List *only one* ceuse *on* eech line.

Approximete Interval Between Onset and Deeth

Immediete Cause (Final disease or condition resulting in deeth)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as e consequence ot):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest
b.

Due to (or es e consequence of):
c.

Dua to (or as a consequence of):
d.

Pert II. **Other aignificant conditiona** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1[ ] Yaa 2[ ] No 3[ ] Probably 4[X] Unknown

24a. Wes an autopsy performed? INSPECTION 1[ ] Yes 2[X] No

24b. Were eutopsy findings availeble prior to completion of cause of death? 1[ ] Yes 2[ ] No

25. Was cese referred to medicel examiner? 1[X] Yes 2[ ] No

26. Place of Deeth *(Check only one)*: Hospitel: 1[ ] Inpatiant 2[ ] ER/Outpetient 3[ ] DOA Other: 4[ ] Nursing Home 5[ ] Residence 6[X] Other *(Specify)* AT SCENE

27. Manner of Death: 1[X] Netural 2[ ] Accident 3[ ] Suicida 4[ ] Homicide 5[ ] Pending investigetion 6[ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1[ ] Yes 2[ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1[ ] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner as stated. 2[X] **Medical Examiner**: On tha basis of exeminetion and/or invastigation, in my opinion, death occurred at tha tima, data and piece, and due to the cause(s) and manner steted.

29b. Signatura and titla of certifier: ▶
29c. Licensa number: OCME
29d. Date signed *(Month, Dey, Year)*: JANUARY 13, 2001

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): David R Farber 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 17 2001
32. Registrer's Signature: ▶ Jenna G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02943

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Theresa Tasker

2. Date of Death Month Day Year: Jan. 20, 2001

3. Time of Death: 8:15AM

4a. Facility Name *(If not institution, giva street and number)*: Shore Nursing and Rehabilitation Center

4b. City, Town, or Location of Death: Denton

4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 577-42-7050

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthdey)*: 90 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Aug.13,1910

9. Birthplece *(Stete or Foreign Country)*: Md

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. Stete: Md

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 13923 Travilah Road

10f. Zip Code: 20850

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar In U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 11 H.S. grad | College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: secretary

16b. Kind of Business/Industry: Fuel

17. Father's Nama *(First, Middle, Last)*: John Zell

18. Mother's Name *(First, Middle, Meiden Surneme)*: Grace (unknown)

19e. Informent's Neme/Reletionship *(Type, Print)*: Wilbert Tasker

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 13923 Travilah Rd.,Rockville,Md.20850

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removel from Steta 4☐ Donetion 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Capitol Crematory

Dete: 1/21/01

20c. Location - City or Town, Stete: Dover, Delaware

21. Signeture of Funeral Service Licensee: Randolph P. Moore

22. Name end Address of Facility: Moore Funeral Home, P.A. 12 S. 2nd Street, Denton, Md. 21629

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Pert1. Enter the disaasa, or complications thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onsat end Daath

Immediete Ceuse (Finel disaese or condition resulting in death)
e. Cerebrovascular accident — 5d.
Dua to (or as a consequence of):
b. Atherosclerosis — 10y

Sequentially list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Atrial fibrillation

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)* | 28b. Time of Injury M | 28c. Injury et Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete and plece, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: MD

29c. License number: D35284

29d. Dete signed *(Month, Dey, Year)*: 1/21/2001

30. Name and address of person who completed ceusa of deeth (Item 23a) (Type, Print): ANDREA ALLEN MD 219 S. Washington St Easton MD 21601

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 22 2001

32. Registrer's Signeture: Denise G. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #'s 10a.& 12.Per FH PGC 1-16-01

Certificate of Death

Reg. No. 2001 02944

TOLLAND, MICHAEL

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL L. TOLAND
2. Date of Death (Month, Day, Year): JANUARY 07, 2001
3. Time of Death: 12:07 AM
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL COUNTY

Funeral Director

5. Social Security Number: 579-80-0207
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 26, 1958
9. Birthplace (State or Foreign Country): WASHINGTON, DC

Usual Residence of Decedent

10a. State: ~~None~~ D.C.
10b. County: N/A
10c. City, Town or Location: WASHINGTON, ~~D.C.~~
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 624 RIDGE ROAD S.E.
10f. Zip Code: 20019
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: ~~Ukn~~ Unk.
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): G.E.D. / College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CARPENTRY
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): WILLIE TOLAND
18. Mother's Name (First, Middle, Maiden Surname): GERALDINE WANNAMAKER TOLAND

19a. Informant's Name/Relationship (Type, Print): WILLIE G. TOLAND/BROTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 624 RIDGE ROAD S.E., WASHINGTON, D.C. 20019

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND NAT. CEMETERY
Date: JAN. 13, 2001
20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: Edward M. Dudley
22. Name and Address of Facility: DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiec or respiretory arrest, shock, or haart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. INTRACTABLE VENTRICULAR TACHYCARDIA — MINUTES

Due to (or as a consequence ot):
b. CARDIO RESPIRATORY ARREST — MINUTES TO HOURS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last

Due to (or as a consequence ot):
c. BILATERAL FRONTAL LOBE GLIOMAS — MONTHS TO YEARS.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: SEIZURE DISORDER, URINARY TRACT INFECTION.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion ot cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place ot Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best ot my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Rangarajan MD
29c. License number: D54288
29d. Date signed (Month, Day, Year): January 7th 2001

30. Name and address of person who completed cause ot death (Item 23a) (Type, Print): 7445, Furnace Branch Rd, Glen Burnie MD 21060. RANGARAJAN

State Registrar

31. Date filed (Month, Day, Year): JAN 16 2001
32. Registrar's Signature: Bernice G. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

3

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02945

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Myrtle Beckwith Tynes
2. Date of Death (Month, Day, Year): January 4, 2001
3. Time of Death: 9:30 PM

4a. Facility Name *(If not institution, give street and number)*: 13910 Berryville Rd.
4b. City, Town, or Location of Death: Seneca
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-28-6831
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 13,1923
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Locatior: Seneca
10d. Inside City Limits: ☒Yas 2☐No
10e. Street and Number: 14054 Berryville Rd.
10f. Zip Coda: 20874
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12th | Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Bus Driver
16b. Kind of Business/Industry: Montgomery County Govt.

17. Fathar's Nama *(First, Middle, Last)*: Unknown
18. Mother's Nama *(First, Middle, Maiden Surname)*: Mamie Beckwith

19a. Informent's Neme/Relationship *(Type, Print)*: Heru Tynes-Mboye (Son)
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 13910 Berryville Rd. Seneca, MD. 20874

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cemetery, cremetory or othar placa)*: Seneca Community Church Cemetery
Data: 01/11/01
20c. Location - City or Town, Stata: Seneca, Maryland

21. Signature of Funeral Service Licensee: [signature] 010105
22. Nama and Address of Facility: Pope Funeral Homes 11315 Lockwood Dr, Silver Spring, MD. 20904

Physician /Medical Examiner

23a. Part1. Enter tha disaase, or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart faitura. List only ona causa on aach lina.

Approximata Interval Batwean Onset and Death

Immediata Causa (Finat disaasa or condition resulting in death)
a. Arteriosclerotic Cerebrovascular Disease
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Causa (Disaase or Injury that initieted events resulting in death) Last
b.
Dua to (or as a consequance of):
c.
Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yas 2☒ No

25. Wes case referred to medical examiner? 1☒ Yas 2☐ No
26. Placa of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Othar: 4☐ Nursing Home 5☐ Residence 6☒ Othar *(Specify)* Son's Residence

27. Manner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined
26a. Deta of Injury *(Month, Dey Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Placa of Injury - At home, farm, streat, fectory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete end ptaca, and dua to tha cause(s) and mannar stated.

29b. Signature and title of certifier: [signature] M.D. (OME)
29c. Licansa number: D15236
29d. Dala signed *(Month, Day, Year)*: January 11, 2001

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print): Carl I. Margolis, M.D. 11125 Rockville Pike, Rockville, MD. 20852

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 2001
32. Registrar's Signature: [signature] G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02946

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Terrell D. Thompson
2. Date of Death (Month, Day, Year): JAN. 12, 2001
3. Time of Death: 4:12 PM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH of SOUTHERN MARYLAND
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-74-3881
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 45 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 1, 1955
9. Birthplace (State or Foreign Country): WASH. D.C.

Usual Residence of Decedent

10a. State: MD.
10b. County: PRINCE GEORGES
10c. City, Town or Location: CLINTON
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 9211 STUART LANE
10f. Zip Code: 20735
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☑ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MECHANIC
16b. Kind of Business/Industry: AUTOMOTIVE

17. Father's Name (First, Middle, Last): PRESTON JENKINS
18. Mother's Name (First, Middle, Maiden Surname): LULA M. THOMPSON

19a. Informant's Name/Relationship (Type, Print): LULA M. THOMPSON MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3217 28TH PARKWAY TEMPLE HILLS, MD. 20748

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
Date: 1-19-01
20c. Location - City or Town, State: SUITLAND, MD.

21. Signature of Funeral Service Licensee: Thomas B. Hunt
22. Name and Address of Facility: HUNT FUNERAL HOME 908 KENNEDY ST. N.W. WASH. D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Septicemia
Due to (or as a consequence of):
b. Possible skin, upper & lower Respiratory
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Bedridden
Due to (or as a consequence of):
d. Brain Tumor - Craniopharyngioma

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure
HTN → Hypertension
Altered mental status.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D-51520
29d. Date signed (Month, Day, Year): 01-17-2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K. DAYACHI, M.D. 1328 SOUTHERN AVE. S.E. #202 WASH. DC. 20032

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: B. Sparks

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02947

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Constancio Tablada

2. Date of Death (Month, Day, Year): January 17, 2001

3. Time of Death: 12:20pm

4a. Facility Name *(If not institution, give street and number)*: Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-78-3238

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 12 1939

9. Birthplace *(State or Foreign Country)*: Phillippines

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: New Carrollton

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 5916 89th. Ave.

10f. Zip Code: 20784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Filipino

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Banquet Waiter

16b. Kind of Business/Industry: Capital Hilton

17. Father's Name *(First, Middle, Last)*: Buenaventura Tablada

18. Mother's Name *(First, Middle, Maiden Surname)*: Flor Leanda

19a. Informent's Name/Reletionship *(Type, Print)*: Agnes Tablada (Wife)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5916 89th. Ave. New Carrollton, MD 20784

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Gate Of Heaven Cemetery

Date: 1/20/01

20c. Location - City or Town, Stete: Silver Spring, MD

21. Signeture of Funeral Service Licensee: Rendon Hale

22. Name and Address of Facility: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

e. SEPTIC Shock

Due to (or as a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest

b. Pneumonia

Due to (or es a consequence of):

c. End stage renal disease + cancer

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure

Acute myocardial infarct

cancer of lung

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Wilhelmina M. Cruz

29c. License number: D20633

29d. Date signed *(Month, Day, Year)*: 1/18/01

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): WILHELMINA M. CRUZ MD - Doctors Community Hospital 8118 Good Luck Rd Lanham Md.

State Registrar

31. Dete filed *(Month, Dey, Year)*: JAN 19 2001

32. Registrer's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Constancio Leanda Tablada

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02948

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: David Charles Usilton
2. Date of Death (Month, Day, Year): January 2, 2001
3. Time of Death: 8:50 a.m.
4a. Facility Name *(If not Institution, give street and number)*: 43473 St. Andrew's Church Road
4b. City, Town, or Location of Death: Leonardtown
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 215-09-7009
6. Sex: 1 ■ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug. 31, 1917
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Leonardtown
10d. Inside City Limits: 1 ☐ Yes 2 ■ No
10e. Street and Number: 43473 St. Andrew's Church Road
10f. Zip Code: 20650
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ■ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 ☐ No — If Yes, Give Year or Dates: 1940 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ■ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Optician
16b. Kind of Business/Industry: Opticianry

17. Father's Name *(First, Middle, Last)*: Thomas B. Usilton, Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Agnes G. West

19a. Informant's Name/Relationship *(Type, Print)*: Wife Kathleen Shannonhouse Usilton
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 43473 St. Andrew's Church Road, Leonardtown, MD 20650

20a. Method of Disposition: 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Paul's Methodist
Date: 1-6-01
20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Mary B. Rizzo MO1114
22. Name and Address of Facility: Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. uremia — 2wk

Due to (or as a consequence of):
b. end stage renal Disease — > 1yr.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
neuropathy

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John F. Fenwick
29c. License number: D0138
29d. Date signed *(Month, Day, Year)*: 1.08.01
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOhn F. Fenwick, M.D., 22650 Cedar Lane Court, Leonardtown, Maryland 20650

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 2001
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

[illegible]

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02949

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Francis Venuto

2. Date of Death (Month, Day, Year): January 14, 2001

3. Time of Death: 1:55 pm

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-30-4447

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 3, 1927

9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1301 Madison Street

10f. Zip Code: 20782

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Operating Engineer

16b. Kind of Business/Industry: US Department of Energy

17. Father's Name (First, Middle, Last): Salvatore Venuto

18. Mother's Name (First, Middle, Maiden Surname): Carmela Figliozzi

19a. Informant's Name/Relationship (Type, Print): Shirley L. Venuto/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1301 Madison Street, Hyattsville, MD 20782

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Parklawn Memorial Park

Date: Jan 18 2001

20c. Location - City or Town, State: Rockville, MD

21. Signature of Funeral Service Licensee: Eric J Scerbo

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RENAL FAILURE — 4 YEARS

Due to (or as a consequence of):
b. ATHEROSCLEROSIS — 15 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. HYPERTENSION — 15 YEARS

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles M Benner

29c. License number: D31563

29d. Date signed (Month, Day, Year): JANUARY 14, 2001

30. Name and address of person who completed cause of death.(Item 23a) (Type, Print): CHARLES M. BENNER MD 11251 LOCKWOOD DRIVE, SILVER SPRING MD 20901

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001

32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02950

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Wilhelmine Anna Vest-Riedel

2. Date of Death — Month: January Day: 16 Year: 2001

3. Time of Death: 9:23AM

4a. Facility Name *(If not institution, give street and number)*: 39404 Mount Wolfe Road

4b. City, Town, or Location of Death: Charlotte Hall

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 231-36-4693

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 17, 1926

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Charlotte Hall

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 39404 Mount Wolfe Road

10f. Zip Code: 20622

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - Amarican Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+): 3

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Administrator

16b. Kind of Business/Industry: Radio

17. Father's Name *(First, Middle, Last)*: Willibald Brein

18. Mother's Neme *(First, Middle, Meiden Surname)*: Anna Maier

19a. Informent's Neme/Reletionship *(Type, Print)*: Annamaria G. Borel/Daughter

19b. Meiling Address *(Streat and Number or Rural Route Number, City or Town, State, Zip Code)*: 39404 Mt. Wolfe Road Charlotte Hall, MD 20622

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or othar piece)*: Trinity Memorial Grdns.

Dete: Jan. 22,2001

20c. Location - City or Town, Stata: Waldorf, Maryland

21. Signetura of Funaral Sarvice Licensee: Joseph Brinsfield

22. Nama and Address of Facility: Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Road Charlotte Hall, MD 20622

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseesa or condition resulting in death): e. Probable Myocardial Infarction — Sec

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immedieta cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

b. Due to (or es e consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Recurrant Pneumonia

Chronic lung disease.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Yeer)*: —

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred: —

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: —

28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*: —

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: William Boyd, II, MD

29c. License number: D14285

29d. Data signed *(Month, Day, Year)*: 1-16-01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William Boyd, II, MD Leonardtown, Maryland 20650

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 19 2001

32. Registrer's Signeture: Donna P. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02951

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Delores	May	VanSteenburg	January 8, 2001	9:11 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St. Mary's Hospital	Leonardtown	St. Mary's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
378-28-6089	1☐ M 2☒ F	68 Yrs.			March 12,1932	Michigan

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	St. Mary's	Great Mills	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
22005 Victoria Circle	20634	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th Grade		School Bus Driver	Board of Education

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Charles F. Pickard	Lydia Weber

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cynthia E. Brown (Daughter)	22005 Victoria Circle, Great Mills, Maryland 20634

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Brinsfield-Echols	1/12/200	Charlotte HAll, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Mary B. Rizzo M0114	Brinsfield Funeral Home, P.A. P.O. Box 279, Leonardtown, Maryland 20650

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Probable Myocardial Infarction — Sec

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	—	M	1☐ Yes 2☐ No	—

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
—	—

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ [signature]	D14285	1-09-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Boyd, II, MD Leonardtown, Maryland 20650

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 11 2001	[signature]

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02952

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John B. Verdon
2. Data of Death (Month, Day, Year): January 16, 2001
3. Time of Death: 4:28pm
4a. Facility Name *(If not institution, give street and number)*: Springbrook Adventist Nursing Home
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 368-16-3202
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Apr. 29, 1919
9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street and Number: 12325 New Hampshire Avenue
10f. Zip Code: 20904
10g. Citizen of What Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Representative
16b. Kind of Business/Industry: Paper
17. Father's Name *(First, Middle, Last)*: Lawrence Verdon
18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Buckingham
19a. Informant's Name/Relationship *(Type, Print)*: Ann Leisenring / Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15228 Aylesbury Street, Silver Spring, MD 20905
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory
Data: 01/19/01
20c. Location - City or Town, State: Beltsville, Maryland
21. Signature of Funeral Service Licensee: Richard Spann
22. Name and Address of Facility: Hines-Rinaldi 11800 New Hampshire Avenue Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Influenza Pneumonia. — 2d.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease, Chronic Renal Failure, Hypertension, Alcoholic Liver Disease, Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stuart Turkewitz
29c. License number: D31001
29d. Date signed *(Month, Day, Year)*: Jan. 17, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stuart J. Turkewitz, M.D. 7500 Greenway Cntr. Dr. #430 Greenbelt, MD. 20770

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02953

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES VELASCO
2. Date of Death (Month, Day, Year): January 17, 2001
3. Time of Death: 6:45P.
4a. Facility Name *(If not institution, give street and number)*: 4708 Cardinal Avenue
4b. City, Town, or Location of Death: Beltsville
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 522-18-5602
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct.11,1919
9. Birthplace *(State or Foreign Country)*: Limon,Mexico

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4708 Cardinal Avenue
10f. Zip Code: 20705
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Research Chemist
16b. Kind of Business/Industry: U.S.D.A

17. Father's Name *(First, Middle, Last)*: Salvador Velasco
18. Mother's Name *(First, Middle, Maiden Surname)*: Manuela Pelayo

19a. Informant's Name/Relationship *(Type, Print)*: Anna Velasco - wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: same as #10a - 10g

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National Cemetery
Date: 1/25/01
20c. Location - City or Town, State: Arlington,Virginia

21. Signature of Funeral Service Licensee: Donald V. Borgwardt
22. Name and Address of Facility: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC CANCER - UNKNOWN PRIMARY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D55559
29d. Date signed *(Month, Day, Year)*: January 19, 2001

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): Thomas Maslen, M.D. 7525 Greenway Center Drive, #316 Greenbelt, Maryland 20770

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02954

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Celestine (Sally) Ann Waldron
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 7:20 am
4a. Facility Name (If not institution, give street and number): Genesis Eldercare- Layhill Center
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 214-48-9899
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 12, 1927
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1400 Fenwick Lane, #909
10f. Zip Code: 20910
10g. Citizen of What Country: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): None
16b. Kind of Business/Industry: At Home

17. Father's Name (First, Middle, Last): David Waldron
18. Mother's Name (First, Middle, Maiden Surname): Collette Bell

19a. Informant's Name/Relationship (Type, Print): David L. Waldron / Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9804 Forest Grove Drive, Silver Spring, MD 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Arlington National Cemetery
Date: Jan 19 2001
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Andrew J. Cole
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Severe, Chronic Psychiatric Disease with Pseudodementia
Due to (or as a consequence of):
b. and Catatonic State — 2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Intrathoracic stomach with gastroesophageal reflux
Disease and Severe esophigitis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: George F. Sengstack MD
29c. License number: D 12121
29d. Date signed (Month, Day, Year): January 13, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): George F. Sengstack, MD 3929 Ferrara Drive, Wheaton, MD 20906

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: for G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02955

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ISAAC STANLEY WATERS
2. Date of Death: Month: January Day: 16 Year: 2001
3. Time of Death: 1220
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 218-16-9123
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-24-23
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. 10b. County: WICOMICO 10c. City, Town or Location: SALISBURY 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 404 - HEARN LANE 10f. Zip Code: 21801 10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: ARMY WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WORKED ON HIGHWAY

16b. Kind of Business/Industry: SOMERSET Co. RD.

17. Father's Name (First, Middle, Last): JOHN WATERS

18. Mother's Name (First, Middle, Maiden Surname): MOLLY WATERS

19a. Informant's Name/Relationship (Type, Print): DELORES THAXTON - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 - HEARN LANE, SALISBURY, MD. 21801

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): DOVER CREMATORY Date: 1/22/01

20c. Location - City or Town, State: DOVER, DELAWARE

21. Signature of Funeral Service Licensee: [signature] for L

22. Name and Address of Facility: BENNIE SMITH F/H 917-W. ISABELLA ST, SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Asystole
Due to (or as a consequence of):
b. Cardiogenic shock.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Septic shock
Due to (or as a consequence of):
d. Sepsis unknown source

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerotic peripheral Vascular disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D19289

29d. Date signed (Month, Day, Year): 1-16-2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Clayton L Raab MD 400 Eastern Shore Dr Salisbury MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

218 16 9123

ISAAC WATERS

1+1VA DQ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02956

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph James Wells

2. Date of Death: Month January Day 18 Year 2001

3. Time of Death: 4:36 AM

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 220-32-7760

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 2/16/1936

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6712 Public Landing Road

10f. Zip Code: 21863

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1953-1956

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Building

17. Father's Name (First, Middle, Last): Fred Wells

18. Mother's Name (First, Middle, Maiden Surname): Helen Taylor

19a. Informant's Name/Relationship (Type, Print): Christine Wells/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 185, Snow Hill, MD 21863

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Spence Church Cemetery

Date: 1/20/2001

20c. Location - City or Town, State: Snow Hill, Maryland

21. Signature of Funeral Service Licensee: William M Short

22. Name and Address of Facility: Short Funeral Home 13 E. Grove Street Delmar, DE 19940

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL + LUNG CANCER — 2 years / 3 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD

T-E FISTULA

ASPIRATION PNEUMONIA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas R. Ulen MD

29c. License number: D0030734

29d. Date signed (Month, Day, Year): 1/18/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PENINSULA REGIONAL MEDICAL CENTER BOX 379 SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001

32. Registrar's Signature: Deanna B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

RALPH WELLS SS# 220-32-7760 1-18-01 0436 4405

6 mo IVA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02957

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Milton Darnell Winder

2. Date of Death Month / Day / Year: January 17, 2001

3. Time of Death: 3:35 PM

4a. Facility Name *(If not institution, give street and number)*: 25756 Quinton Road

4b. City, Town, or Location of Death: Mardela Springs

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 213-70-9135

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 24, 1957

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Mardela Springs

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 25756 Quinton Road

10f. Zip Code: 21837

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: laborer

16b. Kind of Business/Industry: Dresser-Wayne Industries

17. Father's Name *(First, Middle, Last)*: Thomas Lee Winder, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Deliah Horsey

19a. Informant's Name/Relationship *(Type, Print)*: Teresa Winder/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 25756 Quinton Road - Mardela Springs, MD 21837

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Zion UM Church Cemetery

Date: 1/23/01

20c. Location - City or Town, State: Sharptown, Maryland

21. Signature of Funeral Service Licensee: Patricia A Jolley

22. Name and Address of Facility: 1213 Jersey Road - Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Myeloma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☑Residence 6☐Other *(Specify)*

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: Mousavi MD

29c. License number: 1859

29d. Date signed *(Month, Day, Year)*: 1-18-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MIR M. MOUSAVI, MD 701 MIDDLEFORD RD, SEAFORD, DE 19973

State Registrar

31. Date filed *(Month, Day, Year)*: 1-18-JAN 19 2001

32. Registrar's Signature: [signature]

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 DQ

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 10e per F.D. 01/18/2001, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02958

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Tina Marie Wertman

2. Date of Death Month Day Year: Jan. 14, 2001

3. Time of Death: 9:52 PM

4a. Facility Name (If not institution, give street and number): Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-02-4114

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 33 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 3, 1967

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Eldersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: ~~6556 Kali Sr.~~ 6556 Kali Dr.

10f. Zip Code: 21784

10g. Citizen of What Country: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Amaricen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Office Administrator

16b. Kind of Business/Industry: Applied Physics Lab

17. Father's Name (First, Middle, Last): Raymond L. Colley

18. Mother's Neme (First, Middle, Maiden Surname): Joan Carroll Fyock

19a. Informant's Name/Relationship (Type, Print): Larry W. Wertman - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6556 Kali Dr. Eldersburg, MD 21784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Nama of cemetery, crematory or other place): Loudon Park Cemetery Data: 1/18/2001

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funaral Service Licensee: ▶ James B Conroy

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finat disease or condition resulting in death)

a. METASTATIC BREAST CA — 8 MOS

Due to (or as a consequenca of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of axamination end/or Investigation, In my opinion, death occurred at the time, date and piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ Flavio Kruter MD

29c. License number: D3539 &

29d. Data signed (Month, Day, Year): 1-17-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FLAVIO KRUTER, M.D. 555 South Cater Street Westminster, Md 21157

State Registrar

31. Date filed (Month, Day, Year): JAN 18 2001

32. Registrar's Signature: Donna B Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02959

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIVIAN WARNICK
2. Date of Death Month Day Year: January 3, 2001
3. Time of Death: 9:00 P.M.
4a. Facility Name *(If not institution, give street and number)*: RANDOLPH HILLS NURSING HOME
4b. City, Town, or Location of Death: Wheaton
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 073-12-9479
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb. 7,1915
9. Birthplace *(State or Foreign Country)*: Atlanta,Ga.

Usual Residence of Decedent

10a. State: New York
10b. County:
10c. City, Town or Location: New York
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 706 Riverside Drive Apt. 9A
10f. Zip Code: 10031
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, Whita, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+): +06
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Teacher
16b. Kind of Business/Industry: Public School of NY

17. Father's Name *(First, Middle, Last)*: James Stamper
18. Mother's Nema *(First, Middle, Maiden Surname)*: Valerie Hayes

19a. Informant's Name/Relationship *(Type, Print)*: Ruby Hughes/sister
19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 12010 Bernard Drive Wheaton,Md. 20902

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Park View Cemetery
Data: 1/8/01
20c. Location - City or Town, Stata: Schenectady,New York

21. Signature of Funeral Service Licensee: W. D. Griffin
22. Nama and Address of Facility: Frazier's Funeral Home,Inc. 389 R.I. Ave., N.W. Washington,D.C. 20001

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on aach line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 1 Month

Due to (or as a consequence of):
Multi Infarct Dementia — Years

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or es a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.
Intracranial hemorrhage

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yas 2☐ No

25. Was case refarred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Homa 5☐ Residence 6☐ Othar *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be detarmined
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner es stated. 2☐ **Medical Examiner:** On the besis of axaminetion and/or investigation, in my opinion, deeth occurred at the time, data end place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Martin C Shargel MD
29c. License number: D08944
29d. Data signed *(Month, Day, Year)*: January 04, 2001

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Martin C. Shargel, MD 3720 Farragut Avenue Kensington,Md. 20895-2110

State Registrar

31. Data filed *(Month) (Day) (Year)*: JAN 17 2001
32. Registrar's Signature: J. Sparks

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit copy.

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Per. Dr. N.E.
Amend #s 23a 26 1/17/01 PGC ELM

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02960

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH WASHINGTON
2. Date of Death (Month, Day, Year): January 11, 2001
3. Time of Death: 3:00 PM
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-10-5690
8. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 7, 1914
9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Brentwood
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 4502 39th Street
10f. Zip Code: 20722
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Dancer
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Edgar Anderson
18. Mother's Name (First, Middle, Maiden Surname): Celestine Gardner

19a. Informent's Name/Relationship (Type, Print): Celestine Williams/ Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4502 39th Street, Brentwood MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Dispoaition (Name of cemetery, cremetory or other place): Resurrection Cemetery
Data: 1/16/01
20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee: Janice Edwards
22. Name and Address of Facility: Hodges & Edwards Funeral Home, 3910 Silver Hill Road, Suitland, MD 20746

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Acute aspiration event pneumonia
Due to (or as a consequence of):
b. Emesis
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
c. Gastric retention and gastroesophageal reflux
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Dementia with dysphagia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Norton Elsen MD
29c. Licensa number: D20362
29d. Date signed (Month, Day, Year): JAN 12, 2001
30. Name and address of parson who completed cause of death (Item 23a) (Type, Print): Norton Elsen MD 6525 Belcrest Rd Hyattsville, MD 20782

State Registrar

31. Date filed (Month, Day, Year): JAN 17 2001
32. Registrar's Signature: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02961

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Loranzie Otha Wallace
2. Date of Death Month / Day / Year: January 15 2001
3. Time of Death: 09:12 a.m.

4a. Facility Name *(If not institution, give street and number)*: 48192 Hillside Drive
4b. City, Town, or Location of Death: Lexington Park
4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 234-32-6729
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: December 26, 1923
9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: St. Mary's
10c. City, Town or Location: Lexington Park
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 48192 Hillside Drive
10f. Zip Code: 20653
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Water Treatment Operator
16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Frederick Cecil Wallace
18. Mother's Name *(First, Middle, Maiden Surname)*: Hettie Estus Lovell

19a. Informant's Name/Relationship *(Type, Print)*: David K. Wallace / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 24455 Morgan Road, Hollywood, Maryland 20636

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Charles Memorial Gardens — Date: 01/18/2001
20c. Location - City or Town, State: Leonardtown, Maryland

21. Signature of Funeral Service Licensee: Michael L. Gardiner
22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Kidney
Due to (or as a consequence of):
b.
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D19917
29d. Date signed *(Month, Day, Year)*: 1/17/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James E. Boyd, MD — California, Maryland 20619

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 17 2001
32. Registrar's Signature: Barbara B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02962

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Viola Deloris WARD
2. Date of Death: Month January Day 18 Year 2001
3. Time of Death: 10:45 p.m.
4a. Facility Name (If not institution, give street and number): 111 Elm Street
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington

Funeral Director

5. Social Security Number: 234-62-4615
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 12, 1940
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 111 Elm Street
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12 | College (1-4 or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): registered nurse
16b. Kind of Business/Industry: health department

17. Father's Name (First, Middle, Last): Clarence Sirk
18. Mother's Name (First, Middle, Maiden Surname): Wilda Sirk

19a. Informant's Name/Relationship (Type, Print): Mr. Charles W. Ward - husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 Elm Street, Hagerstown, Maryland 21740

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Samples Manor
Date: Jan. 23, 2001
20c. Location - City or Town, State: Sharpsburg, Maryland

21. Signature of Funeral Service Licensee: ▶ Jack L. Minnich
22. Name and Address of Facility: Minnich Funeral Home, 415 East Wilson Blvd., Hagerstown, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiorespiratory Failure — Few days
Due to (or as a consequence of):
b. Cardiac Arrythmia — Few Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive Heart Failure — Few Years
Due to (or as a consequence of):
d. Hypertensive Heart Disease — Several Yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary Artery Disease
Diabetes Mellitus
Peptic Ulcer Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ D.A. Calcagno MD
29c. License number: D35497
29d. Date signed (Month, Day, Year): 1/22/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DANIEL A. CASHA MD 376 Mill St. Hagerstown MD 21740

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001
32. Registrar's Signature: Brenda P Ayers

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02963

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH FELIX WOJECK
2. Date of Death (Month, Day, Year): January 21, 2001
3. Time of Death: 11:30 PM
4a. Facility Name (If not institution, give street and number): 16904 Shinham Road
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington County

Funeral Director

5. Social Security Number: 188-18-0083
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): Aug. 27, 1921
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Washington Co.
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 502 Rhode Island Avenue
10f. Zip Code: 21740
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foreman
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Stanley Woyick
18. Mother's Name (First, Middle, Maiden Surname): Margaret Novack

19a. Informant's Name/Relationship (Type, Print): Stephen J. Wojeck/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16904 Shinham Road, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rest Haven Cemetery
Date: Jan.25
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Douglas A. Fiery Funeral Home 1331 Eastern Blvd.,N.,Hagerstown,Maryland 21742

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HYPOXEMIA
Due to (or as a consequence of):
b. RECURRENT SEIZURES — 2 DAYS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. GLIOBLASTOMA MULTIFORME — OCT 2000
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
MULTIPLE MYELOMA

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [✓] Other (Specify) Son's Home

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and Title of Certifier: [signature] FAMILY PHYSICIAN
29c. License number: D1706
29d. Date signed (Month, Day, Year): 1/23/2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN E. METZNER, MD 747 NORTHERN AVENUE HAGERSTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 23 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02964

Name: Anna Irene Welty

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
ANNA IRENE WELTY	January 21, 2001	7:00 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
REEDERS MEMORIAL HOME	BOONSBORO	WASHINGTON

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
219-52-1585	1☐ M 2☒ F	95 Yrs.			JULY 21,1905	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	WASHINGTON	BOONSBORO	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
107 LAKIN AVENUE	21713	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CARMIE BENTON HUTZELL	EDNA DAISY SMITH

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
VAUGHN R. WELTY/SON	107 LAKIN AVENUE, BOONSBORO, MARYLAND 21713

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	BOONSBORO CEMETERY	1/24/01	BOONSBORO, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Paul M Dean	Paul m. Dean / BAST FUNERAL HOME / 7606 Old national Pike Boonsboro, Maryland 21713

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. cerebro vascular accident	hours
Due to (or as a consequence of):	b. atrial fibrillation	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	D32518	1/22/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. Robert Guedenet 100 Geeting Lane, Keedysville, Maryland 21756/301-432-2222

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 23 2001	

DHMH 16 Rev 6/95

ORIGINAL

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02965

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Englebert E. Warzinsky
2. Date of Death: Month January Day 16 Year 2001
3. Time of Death: 6:46pm
4a. Facility Name (If not institution, give street and number): 11235 Oakleaf Drive #412
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 202 10 6746
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 4, 1921
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10a. Street and Number: 11235 Oakleaf Drive #412
10f. Zip Code: 20901
10g. Citizen of What Country: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1940-1951
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): National Security Agency
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Michael Warzinsky
18. Mother's Name (First, Middle, Maiden Surneme): Annele Rastusky

19a. Informant's Name/Reletionship (Type, Print): Anna Mae Danouski (Niece)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 209 South Ferguson St. Shenandoah, PA 17976

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremetion 3 [X] Removal from Stete 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Our lady of Dawn Cemetery
Dete: 1-22-01
20c. Locetion - City or Town, State: Shenandoah, PA

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Hines-Rinaldi 11800 New Hampshire Avenue Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth): a. Chronic Obstructive Pulmonary Disease — 20 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yee 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: [signature]
29c. License number: D31563
29d. Date signed (Month, Day, Year): January 17, 2001

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Charles Benner, M.D. 11251 Lockwood Drive, Silver Spring, Maryland 20901

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: [signature] D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02966

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dewey C. Wheless
2. Date of Death Month / Day / Year: January 16, 2001
3. Time of Death: 3:20 PM
4a. Facility Name *(If not institution, give street and number)*: Cherry Lane NH
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 578-42-1741
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 91 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec 10, 1909
9. Birthplace *(State or Foreign Country)*: Georgia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 9001 Cherry Ln
10f. Zip Code: 20707
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief Petty Officer
16b. Kind of Business/Industry: U.S. Navy

17. Father's Name *(First, Middle, Last)*: Cozvel Wheless
18. Mother's Name *(First, Middle, Maiden Surname)*: Julia Rousey

19a. Informant's Name/Relationship *(Type, Print)*: Margaret Adinolfi/Niece
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15646 Mews Ct, Laurel, MD 20707

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Arlington National
Date: Jan 23
20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: Alan J. Donnell
22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A. Kundrat
29c. License number: D36716
29d. Date signed *(Month, Day, Year)*: January 18, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Kundrat 8317 Cherry Ln, Laurel, MD 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: G. Sparks

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02967

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Theresa Lee Wills
2. Date of Death Month 01 Day 11 Year 01
3. Time of Death: 10:05 AM
4e. Facility Name *(If not institution, give street and number)*: Ft. Washington Hospital
4b. City, Town, or Location of Death: Ft. Washington, MD
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-62-5922
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 54 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 8/28/46
9. Birthplace *(State or Foreign Country)*: Raleigh, NC

Usual Residence of Decedent

10a. State: MD
10b. County: Charles
10c. City, Town or Location: Ft. Washington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 12306 Proxmire Drive
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Data Processor
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: John Wilson
18. Mother's Name *(First, Middle, Maiden Surname)*: Jessie Rogers

19a. Informant's Name/Relationship *(Type, Print)*: Robert Wills Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12306 Proxmire Drive, Ft. Washington, MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln
Date: 1/17/01
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: [signature] M0105
22. Name end Address of Facility: Pope Funeral Home 5538 Marlboro Pike FV 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): ~~Hepatic~~ Encephalopathic — Days
Due to (or as a consequenca of):
b. ~~Hepatic~~ Failure — Weeks
Due to (or as e consequenca of):
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last
c. Metastatic Breast Cancer — Years
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es ateted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D32800
29d. Date signed *(Month, Day, Year)*: 1-15-01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 11701 Livingston Road #205 Ft. Washington, MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: [signature] D. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02968

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Katie Velmon Walton
2. Date of Death (Month, Day, Year): January 9, 2001
3. Time of Death: 11:45 PM
4a. Facility Name (If not Institution, give street and number): Prince Georges Comm. Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-10-1918
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 11, 1912
9. Birthplace (State or Foreign Country): Everts, NC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Mitchellville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 10818 Golf Course Terrace
10f. Zip Code: 20721
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): William Henry Kelliebrew
18. Mother's Name (First, Middle, Maiden Surname): Odie Spruill

19a. Informant's Name/Relationship (Type, Print): Anthony Lee Walton /Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10818 Golf Course Terrace, Mitchellville, MD 20721

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): MD National Cemetery
Date: 1-16-01
20c. Location - City or Town, State: Laurel, Md

21. Signature of Funeral Service Licensee: Katie Jane Moore
22. Name and Address of Facility: Alexander S. POpe Funeral HOme 5538 Marlboro Pike, Forestville, MD 20747

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Septicemia, DIC — 2 weeks
Due to (or as a consequence of):
b. Urinary tract infection, Renal stone
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Congestive heart failure
Due to (or as a consequence of):
d. Mitral valve regurgitation

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sher Rah
29c. License number: D0054140
29d. Date signed (Month, Day, Year): 1/11/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHERVIN RAHMANI, M.D. PGHC 3001 Hospital Drive, Cheverly, MD 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 19 2001
32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02969

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Donald Whittenburg
2. Date of Death (Month, Day, Year): January 12, 2001
3. Time of Death: 12:10 A.M.
4a. Facility Name *(If not institution, give street and number)*: Prince Georges General Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 251-48-9623
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: February 14, 1935
9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Lanham
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 7921 Cawker Ave.
10f. Zip Code: 20706
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: Korean
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No — Specify:
14. Race - American Indian, Black, White, etc. — Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Auto Repair

17. Father's Name *(First, Middle, Last)*: Dewey Whittenburg
18. Mother's Name *(First, Middle, Maiden Surname)*: Solona Foster

19a. Informant's Name/Relationship *(Type, Print)*: Lillian Whittenburg/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7921 Cawker Ave. Lanham, MD 20706

20a. Method of Disposition: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery — Date: January 17, 2001
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Roger A Delbaum
22. Name and Address of Facility: Ft. Lincoln Funeral Home, 3401 Bladensburg Rd. Brentwood, MD 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cerebral anoxia	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Myocardial infarction	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: End stage renal disease - dialysis dependent; Peripheral vascular disease; Sepsis (pseudomonas)

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D 43662
29d. Date signed *(Month, Day, Year)*: 1/12/2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): William J. Boyce, PA Hosp - 3001 Hospital Drive, Cheverly MD 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 19 2001
32. Registrar's Signature: Jennie D. Sparks

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

CPS
00-0037-017
SHIRLEY WILLIAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02970

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHIRLEY ANNA WILLIAMS
2. Date of Death (Month, Day, Year): JANUARY 2, 2001
3. Time of Death: 8:30 PM
4a. Facility Name (If not institution, give street and number): 6026 Swanson Creek Landing
4b. City, Town, or Location of Death: Hughesville
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 079-20-4595
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 62 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 11-01-38
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Hughesville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6026 Swanson Creek Lane
10f. Zip Code: 20637
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Bieck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired): Consultant
16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Charles Forbes
18. Mother's Neme (First, Middle, Meiden Surneme): Doris King

19a. Informent's Neme/Relationship (Type, Print): Gary Forbes / Brother
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3010 Charleton Court, Waldorf, MD 20602

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Chesapeake Crematory
Dete: 1-19-01
20c. Location - City or Town, State: Beltsville, MD

21. Signature of Funeral Service Licensee: Erick L. Strickland
22. Name and Address of Facility: Strickland Funeral Services, PA, 6500 Allentown Rd, Camp Springs, MD 20748

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)
a. Intra-cerebral hemorrhage
Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contributs to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was en autopsy performed? Limited 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion ot cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No
26. Place of Deeth (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence ☒ Other (Specify) scene

27. Menner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homlcide 5☐ Pending Investigetion 6☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and manner as stated. ☒ **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, deeth occurred st the time, dete and place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier: Stephen S. Radentz, M.D.
29c. License number: OCME
29d. Date signed (Month, Day, Year): January 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year): JAN 19 2001
32. Registrer's Signeture: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02971

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene John Yonkoski

2. Date of Death (Month, Day, Year): January 19, 2001

3. Time of Death: 10:00 A.M.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 368-36-0598

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 20, 1937

9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 5280 Genesis Lane

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1958-64

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Rece - American Indien, Biack, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): cartographer

16b. Kind of Business/Industry: Federal government

17. Father's Name (First, Middle, Last): Steve Yonkowski

18. Mother's Name (First, Middle, Maiden Surname): Anna Krotche

19a. Informant's Name/Relationship (Type, Print): Victoria French/ daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 111 Knoxville, MD 21758

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piace of Disposition (Name of cemetery, crematory or other place): St. Peters Cemetery

Date: 1/22/01

20c. Location - City or Town, State: Libertytown, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure — 9 Jan

Due to (or es a consequence of):

b. Cerebral vascular accident (stroke) — 9 Jan

Due to (or as a consequence of):

c. Coronary artery disease — year

Due to (or as a consequence of):

d. Diabetes — year

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

transitional cell carcinoma left kidney, ureter & bladder

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete and piace, end due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert D Crouch MD

29c. License number: D0000976

29d. Date signed (Month, Day, Year): 1/19/01

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROBERT D. CROUCH, MD 900 Toll House Rd FREDERICK MD 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 22 2001

32. Registrar's Signature: Brenda B Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02972

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Catherine L. Yohe

2. Date of Death Month Day Year: January 16, 2001

3. Time of Death: 1525

4e. Facility Name *(If not institution, give street and number)*: Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown, MD

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 235-06-3877

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 08/23/1923

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14014 Marsh Pike

10f. Zip Code: 20179

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Homemaker

17. Father's Name *(First, Middle, Last)*: Floyd Barnhart

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Viola Wagner

19e. Informent's Neme/Relationship *(Type, Print)*: Cornelius Yohe/son

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14 Tyler Dr., East Berlin, PA 17316

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Salem Cemetery

Dete: 01/19/01

20c. Location - City or Town, Stete: Chambersburg, PA

21. Signeture of Funeral Service Licensee: Paul L. Stahlsmith M00849

22. Neme and Address of Feciility: Lochstampfor Funeral Home, Inc. 48 S. Church St., Waynesboro, PA 17268

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Interval Between Onset and Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): a. Pneumonia — (illegible)

Due to (or es a consequence of):

Sequentially list conditions, if any, leading to immediete causa. Enter Underlying Cause (Diseese or injury thet inticted events resulting in deeth) Lest:

b.

Due to (or es a consequence of):

c.

Due to (or es a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

Interio sclerotic cardiovascular Disease

Centro vascular Accident Diebt Mellitus

Peripheral Vascular Disease Chronic Renal

insufficiency Hyperkalemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: MD

29c. License number: D18019

29d. Date signed *(Month, Day, Year)*: JAN 17, 2001

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): VASANT DATTA MD 334 MILL ST HAGERSTOWN, MD 21740

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 24 2001

32. Registrer's Signeture: Donna B Spates

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Yohe, Catherine L.

JAN 5 1981 U.S. MAIL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02973

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Howard Franklin Zabriskie
2. Date of Death Month Day Year: January 14, 2001
3. Time of Death: 11:45 am
4a. Facility Name *(If not institution, give street and number)*: Montgomery Hospice- Casey House
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 135-16-2984
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Feb 14, 1919
9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1604 Timberline Road
10f. Zip Code: 20904
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1944-1946
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) | College (1-4or 5+): 3
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Aviation Metalsmith
16b. Kind of Business/Industry: Aeronautics

17. Father's Name *(First, Middle, Last)*: Myron L. Zabriskie
18. Mother's Neme *(First, Middle, Maiden Sumame)*: Marguerite Sluyter

19a. Informant's Name/Reletionship *(Type, Print)*: Janet C. Sandberg/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1216 Downs Drive, Silver Spring, MD 20904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from Stete 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: South Presbyterian Cemetery | Date: Jan 18 2001
20c. Location - City or Town, State: Bergenfield, NJ

21. Signature of Funeral Service Licensee: William J Byl
22. Neme and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Pnysician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Metastatic Carcinoma — 8 months

Due to (or as a consequence of):
b. Colon Cancer — 2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Venous Stasis Ulcers

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* Hospice

27. Mannar of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: E. P. Libre MD
29c. License number: D 09470
29d. Dete signed *(Month, Day, Year)*: January 15, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): E.P. Libre , MD 10400 Connecticut Ave., Kensington, MD 20895

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 17 2001
32. Registrar's Signeture: G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02974

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Agatha Aiken

2. Date of Death Month: February Day: 2 Year: 2001

3. Time of Death: 1422

4a. Facility Name *(If not institution, give street end number)*: Upper Chesapeake Medical Center

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-30-3236

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 24, 1914

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Md.

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 202 Kimary Ct. Apt. 2A

10f. Zip Code: 21050

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Registered Nurse

16b. Kind of Business/Industry: Nursing

17. Father's Name *(First, Middle, Last)*: Robert Eugene Zimmer

18. Mother's Name *(First, Middle, Maiden Surname)*: Anne Vincentia Fisher

19a. Informant's Name/Relationship *(Type, Print)*: Lloyd E. Aiken - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15 Sacred Heart Lane, Glyndon, Md. 21071

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Dulaney Valley Mem. Gardens

Date: Feb. 6, 2001

20c. Location - City or Town, State: Timonium, Md.

21. Signature of Funeral Service Licensee: H.J. Eckhardt

22. Name and Address of Facility: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILIURE

Due to (or as a consequance of):

b. CORONARY DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ARTERIAL EMBOLISM

Due to (or as a consequence of):

d. EMPHYSEMA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D45921

29d. Date signed *(Month, Day, Year)*: FEBRUARY 4, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED F. MAHMOOD M.D. 4-B NORTH AVENUE SUITE 302 BEL AIR MARYLAND 21014

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature: D. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene, Baltimore, Maryland 21215-0036
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Aiken, Mary A

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02975

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Alfred	A.	Adams	01	29	2001	4:00a. M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Worthington Assist Living	Reisterstown	Baltimore Co.

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
214-14-8411	1 [X] M 2 [ ] F	78 Yrs.			10 22 22	M.D.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Harford	Bel Air	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
523 East Broadway	21014	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [X] Yes 2 [ ] No	1 [ ] Yes [X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10th grade	na	Metal Plater	Westinghouse

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Bernard Adams	Lillian Johnson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Valerie Stump-Daughter	523 East Broadway, Bel Air, Md 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
[X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Garrison Forest Vet.	2/2/01	Owings Mills, Md

21. Signature of Funeral Service Licensee: Dale March

22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC LUNG CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY

ALZHEIMERS DEMENTIA

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [✓] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification; To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Tasneem Lakhani	D28595	1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TASNEEM LAKHANI 7220 PARK HEIGHTS AVE BALTO MD 21208

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	Registrar D. Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02976

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Lenard	Alridge		Feb. 01, 2001	11:00 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Pikesville Nursing Home	Pikesville	Baltimore

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
425-40-1318	1☒M 2☐F	71 Yrs.			9-11-1929	MS

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md	N/A	Baltimore	1☒Yes 2☐No

10a. Street and Number	10f. Zip Code	10g. Citizen of What Country?
633 Aisquith Street	21202	U S A

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
5th grade	N/A	Truck Driver	Construction Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unk	Unk

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Cassie L. Kelley- Daughter	2510 Edgecombe Circle North Apt K Balto, Md 21215

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Voshell Memorial Park	2-6-01	Baltimore, Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
John March	Baltimore, Maryland 21215 WM.C.March FH 4300 Wabash Avenue

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. COPD	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d. Due to (or as a consequence of):	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	037573	Feb 2, 2001

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Jeff Zibell MD 25 Main St. Reisterstown MD 21136

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	

DHMH 16 Rev 6/95

ORIGINAL

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02977

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ELLEN BEEGHLY

2. Date of Death (Month, Day, Year): FEBRUARY 1 2001

3. Time of Death: 10:35AM

4a. Facility Name (If not institution, give street and number): ST VINCENT DEPAUL NURSING CENTER

4b. City, Town, or Location of Death: FROSTBURG

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-10-4195

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JUNE 24 1920

9. Birthplace (State or Foreign Country): MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 48 TARN TERRACE

10f. Zip Code: 21532

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 11th GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOUSEKEEPER

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): BARNEY SYLVESTER MCCARTY

18. Mother's Name (First, Middle, Maiden Surname): MARGARET VIOLA JOHNSON

19a. Informant's Name/Relationship (Type, Print): SUE LINDSAY

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 48 TARN TERRACE FROSTBURG MARYLAND 21532

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND ANATOMY BOARD

Date: 2/01/01

20c. Location - City or Town, State: BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: State Anatomy Board 655 W.BaltimoreStreet, Balto, MD 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CARDIAC Dysrhythmia — 1 HOUR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

ARTERIOSCLEROTIC HEART DISEASE

HISTORY OF SARCOIDOSIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: S Chang MD

29c. License number: D25638

29d. Date signed (Month, Day, Year): FEBRUARY 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SATURNINA T. CHANG 10701 NEW GEORGES CREEK ROAD FROSTBURG MARYLAND 21532

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Denise G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0498-510

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

BELINDA S. BROWN AMENDED ITEM# 1 per ME G797 070301 SS

AMENDED ITEMS# 23a,b,pt II & 27 per ME G792 022001 SS

Certificate of Death

Reg. No 2001 02978

Physician /Medical Examiner

1. Decedent's Nema (First, Middle, Last): BELINDA F. BROWN

2. Date of Death Month Day Year: JAN. 30, 2001

3. Time of Death: 10:30 AM

4a Facility Neme (If not institution, giva street and number): 1435 BONSAL STREET

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 219-58-2598

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 42 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Yeer): JULY 31, 1958

9. Birthplaca (Steta or Foreign Country): MD.

Usual Residence of Decedent

10a. Stete: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 1435 BONSAL ST.

10f. Zip Code: 21224

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowad 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, etc. Specify: WHITE

15. Decedent's Education (Specify only highast grada completed)

Elementary/Secondery (0-12):

College (1-4or 5+): 1

16e. Decedent's Usual Occupation (Giva kind of work done duning most of working life. DO NOT use retired): ADAPT COORDINATOR

16b. Kind of Business/Industry: GENERAL MOTORS

17. Father's Nama (First, Middla, Last): RALPH F. BROWN

18. Mother's Neme (First, Middle, Maiden Sumeme): CATHERINE MACK

19a. Informent's Name/Reletionship (Type, Print): RALPH F. BROWN

19b. Meiling Address (Straet end Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 222 COINJOCK N.C. 27923

20a. Method of Disposition: 1☒ Burial 2☐ Crametion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): BELAIR MEM. GARDENS

Data: FEB. 3 2001

20c. Location - City or Town, State: HARFORD CO. MD.

21. Signature of Funeral Service Licensee: Thomas J. Skoda Jr.

22. Neme end Address of Facility: HOFFMAN-SKODA F.H. 3218 HUDSON ST. BALTO., MD. 21224

Physician /Medical Examiner

23a. Part1. Enter the disease or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in death)

e. SEPSIS

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest

b. ACUTE PYELONEPHRITIS

Due to (or as e consequence of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS, HYPERTENSION

23b. Did tobacco use contribute to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of causa of death? 1☒ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) AT SCENE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated. 2☒ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mennar steted.

29b. Signeture end title of certifier: Dennis J Chute MD

29c. License number: O.C.M.E

29d. Data signed (Month, Day, Year): JAN. 31, 2001

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Jennie G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 7 per fh G792 2/5/01 yf

Certificate of Death

Reg. No. 2001 02979

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mariya Bychkova

2. Date of Death (Month, Day, Year): February 5, 2001

3. Time of Death: 9:28 pm

4a. Facility Name (If not institution, give street and number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-57-5659

6. Sex: 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday): ~~75~~ 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 14, 1926

9. Birthplace (State or Foreign Country): Russia

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Reisterstown

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 12394 Boncrest Drive

10f. Zip Code: 21136

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Homemaking

17. Father's Name (First, Middle, Last): Semyen Anesemov

18. Mother's Name (First, Middle, Maiden Surname): Mariya Anesemova

19a. Informant's Name/Relationship (Type, Print): Alex Bushkov - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12394 Boncrest Dr. Reisterstown, Md. 21136

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): All Saints Cemetery

Date: Feb. 5, 2001

20c. Location - City or Town, State: Reisterstown, Md.

21. Signature of Funeral Service Licensee: Justin R. Dunbar

22. Name and Address of Facility: Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. probably pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. lymphoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Alice Hsieh

29c. License number: H45974

29d. Date signed (Month, Day, Year): February 5 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alice Hsieh, Northwest Hospital Randallstown, MD

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0474-510
CJ
Leroy Blue

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02980

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leroy Blue
2. Date of Death: Month January, Day 28, Year 2001
3. Time of Death: 06:43 P.M.
4a. Facility Name (If not institution, give street and number): Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 239-56-7223
6. Sex: X 1 M 2 F
7. Age (In yrs. last birthday): 61 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 05 23 39
9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD
10b. County: NA
10c. City, Town or Location: Baltimore
10d. Inside City Limits: XX 1 Yes 2 No
10e. Street and Number: 3901 Fernhill Ave
10f. Zip Code: 21215
10g. Citizen of What Country?: U.S.A.

11. Marital Status: XX 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4or 5+): na
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Skilled Laborer
16b. Kind of Business/Industry: Construction Co.

17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Maiden Surname): Lena Blue

19a. Informant's Name/Relationship (Type, Print): Elaine M. Johnson-Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6631 Hunters Wood Circle, Catonsville Md 21228

20a. Method of Disposition: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Vet.
Date: 2/2/01
20c. Location - City or Town, State: Owings Mills, Md

21. Signature of Funeral Service Licensee: Harry A Thompson
22. Name and Address of Facility: March F/H West, 4300 Wabash Ave, Baltimore Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bladder Cancer

Renal insufficiency

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? Limited 1 X Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No

25. Was case referred to medical examiner? XX Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, M.D.
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): January 29, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: James G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02981

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES BIRDSOE
2. Date of Death (Month, Day, Year): 02 01 2001
3. Time of Death: 5:00 PM
4a. Facility Name (If not institution, give street and number): MARINER HEALTH AT NORTH ARUNDEL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 229-72-4971
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10/6/06
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 904 PLEASANTVILLE DRIVE
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER
16b. Kind of Business/Industry: OWN HOME

17. Father's Name (First, Middle, Last): JAMES SMITH
18. Mother's Name (First, Middle, Maiden Surname): VIRGINIA RUTHERFORD

19a. Informant's Name/Relationship (Type, Print): MRS. SYDNEY ELLIOTT (DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 904 PLEASANTVILLE DRIVE, GLEN BURNIE, MD. 21061

20a. Method of Disposition: ☒ 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK | Date: 2/5/2001
20c. Location - City or Town, State: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Bronchopneumonia	1 day
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease, CHF, Mitral Regurgitation, S/P Pacemaker, Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rita Khandelwal Attending Physician
29c. License number: D29873
29d. Date signed (Month, Day, Year): 02/01/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RITA KHANDELWAL, MD 1600 S. CRAIN HWY # 201 GLEN BURNIE, MD. 21061

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

01-0591-003

FRANK BOYER
ASP

1- For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02982

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
FRANK	HOWARD	BOYER	FEBRUARY 03 2001	0548 M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	ANNE ARUNDEL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-50-9585	1☒ M 2☐ F	52 Yrs.			AUG. 26, 1948	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
7900 BENESCH CIRCLE	21060	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	DRYWALL INSTALLER	CONSTRUCTION

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
HOWARD	J.	BOYER	HAZEL	J.	LENTES

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MR. HOWARD BOYER (FATHER)	716 PAMELA ROAD, GLEN BURNIE, MD. 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	CHESAPEAKE CREMATION CENTER, LLC.	02/07/2001	STEVENSVILLE, MD.

21. Signature of Funeral Service Licensee ▶ [signature] MD 2205

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery
1☐ Yes 2☐ No 9☐ Unknown	1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) _____ 9☐ Unknown	Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Bipolar Disorder

23e. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

Medical Certification; To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature]	O.C.M.E	FEBRUARY 04, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. Upton Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	[signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02983

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Margaret Bolewicki

2. Date of Death: Month FEBRUARY Day 1 Year 2001

3. Time of Death: 10:00 A.M.

4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER

4b. City, Town, or Location of Death: ROSEDALE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 217-20-0292

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 28, 1911

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2904 Dunmore Road, Apt. B

10f. Zip Code: 21222

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 years; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Assembly Line

16b. Kind of Business/Industry: Distillery

17. Father's Name (First, Middle, Last): Peter Petruccy

18. Mother's Name (First, Middle, Maiden Surname): Bertha A. Smith

19a. Informant's Name/Relationship (Type, Print): Robert Neuman (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 406 Overview Avenue Baltimore, Maryland 21224

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): First United Evangelical Church of Christ Cemetery

Date: 2/5/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Gregg E. Reed

22. Name and Address of Facility: Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. END STAGE CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 21 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY, HYPERTENSION, ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE PARKINSONS DISEASE, ALZHEIMERS, DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marco Zamora MD

29c. License number: D40819

29d. Date signed (Month, Day, Year): FEBRUARY 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARCO ZAMORA, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: Sandra G Sparks

ORIGINAL

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

BOLEWICKI, GRACE

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

01-0473-510
mnmr
Unknown 01-024
Michael Calligan

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMENDED ITEMS# 23a,27,28a-f per M.E. G792-020701-33

Reg. No. 2001 02984

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month Day Year)	3. Time of Death
MICHAEL A. CALLIGAN, JR.	January 28, 2001	1745 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
526 East 21st Street	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
212-70-1432	1☒M 2☐F	42 Yrs.			Nov.23-1958	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Baltimore County	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
18 Glade Avenue	21236	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - American Indian, Black, White, atc.
1☒Nevar Married 2☐Merried 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yas, Give Yaar or Datas Unknown	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12th grade	N/A	Welder	Tor Co.-Phila. Pa.

17. Father's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
Michael A. Calligan, Sr.	Barbara J. Bichell

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michael A. Calligan,Sr.(Father)	18 Glade Avenue Baltimore, Maryland 21236

20a. Method of Disposition	20b. Piece of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from Stata 4☐Donetion 5☐Other (Specify)	St. Joseph Ch. Cem.	2-5-2001	Baltimore, Md.

21. Signature of Funaral Service Licensee	22. Name and Address of Facility
▶ C. F. Lassahn	Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236

Physician /Medical Examiner

23a. Part1. Entar the disease, or complications that causad tha daath. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or haart failura. List only ona cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. NARCOTIC AND ALCOHOL INTOXICATION
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributs to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☒Yes 2☐No

25. Was cese referred to medicel examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Homa 5☐Residence 8☒Other (Specify) at scene

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined	found 1-28-01	found 5:45p	1☐Yes 2☒No	subject ingested drugs and alcohol

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
found in vacant building	526 E. 21st st. Baltimore, MD

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in *my* opinion, death occurred at the time, date end place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Stephen S. Radentz, M.D.	O.C.M.E.	January 29, 2001

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)
Stephen S. Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	▶ Teresa G. Sparks

DHMH 16 Rev 6/95

ORIGINAL

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02985

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Celestine Carr
2. Date of Death Month Day Year: 01-28-2001
3. Time of Death: 4:45 AM
4a. Facility Name (If not institution, give street and number): 103 WHITE OAKS AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 577-60-8745
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 05-08-1946
9. Birthplace (State or Foreign Country): DC

Usual Residence of Decedent

10a. State: MD
10b. County: BALTIMORE
10c. City, Town or Location: CATONSVILLE
10d. Inside City Limits: 1☐Yes 2☑No
10e. Street and Number: 103 WHITE OAKS AVE.
10f. Zip Code: 21228
10g. Citizen of What Country? USA

11. Marital Status: 1☑Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): 8 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): STEVEN CARR
18. Mother's Name (First, Middle, Maiden Surname): VIOLA STEPHENS

19a. Informant's Name/Relationship (Type, Print): CLEMENTINE CARR | SISTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 WHITE OAKS AVE., BALTO. MD. 21228

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY | Date: 2-03-01
20c. Location - City or Town, State: BLADENSBURG, MD

21. Signature of Funeral Service Licensee: Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE, 5151 BALTO. NATL. PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic breast cancer — 3 1/2 yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Endometrial Cancer

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☑Residence 8☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Nancy L Davidson MD
29c. License number: D28239
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nancy Davidson MD 1650 Orleans St Rm 409 Baltimore MD 21231

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature]

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2001 02986

COOPER, TANCIL

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): TANCIL COOPER
2. Date of Death Month Day Year: JANUARY 29, 2001
3. Time of Death: 1:50 P.M.
4a. Facility Name (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL CENTER
4b. City, Town, or Location of Death: ROSEDALE
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 219-40-5775
6. Sex: 1☑ M 2☐ F
7. Age (In yrs. last birthday): 57 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-23-1943
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 2919 WINSOR AVENUE
10f. Zip Code: 21216
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): MECHANIC
16b. Kind of Business/Industry: WAREHOUSE

17. Father's Name (First, Middle, Last): WILLIAM COOPER
18. Mother's Name (First, Middle, Maiden Surnama): ECOLIA DUNLOP

19a. Informant's Name/Relationship (Type, Print): CECELIA COOPER | WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2919 WINSOR AVE., BALTO. MD. 21216

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY | Date: 2-2-01
20c. Location - City or Town, State: BALTO. MD
21. Signature of Funeral Service Licensee: ▶ Vaughn C [illegible]
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. (Approximate Intarval Between Onset and Death)

Immediata Causa (Final disaasa or condition resulting in death)
a. SEPSIS
Dua to (or as a consequance of):
b. BOWEL PERFORATION

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in tha underlying causa given in Part I.
CORONARY ARTERY DISEASE, ILEUS, ALCOHOL ABUSE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CHRONIC RENAL INSUFFICIENCY, CEREBRAL VASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was casa referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Othar (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending invesfigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To tha best of my knowledge, daath occurred at tha tima, data and placa, and due to tha cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stafed.
29b. Signafure and fitle of certifier: ▶ [illegible]
29c. License number: RD 192732
29d. Data signed (Month, Day, Year): 1/29/01
30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): DR. LANCE BARKER 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD. 21237

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ [illegible]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indellble Ink. Assure All Copies Are Legible.

Amend Item 23a per phy.,G792,02/05/01dhb

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02987

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen I Cromer

2. Date of Death: Month Jan, Day 12, Year 2001

3. Time of Death: 12:10 P.M

4a. Facility Name (If not institution, give street and number): Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 235 38 4579

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 73 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): Dec. 27, 1927

9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 221 Townsend Avenue

10f. Zip Code: 21225

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yas 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐Yes 2☒No Specify:

14. Reca - American Indian, Black, Whita, etc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arch Moats

18. Mother's Name (First, Middle, Maiden Sumame): Rella Phillips

19a. Informant's Name/Reletionship (Type, Print): Michael Cromer / Son

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 316 Tulip Oak Court Linthicum, Maryland 21090

20a. Method of Disposition: 1☒Burial 2☐Cramation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Cedar Hill Cemetery

Date: 1/16/01

20c. Location - City or Town, State: Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Donna M Zremerowski

22. Name and Address of Facility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that causad tha daath. Do not entar the mode of dying, such as cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onsat and Daath

Immediate Ceuse (Finel disease or condition resulting in deeth):

a. Respiratory failure 2° to COPD

Due to (or as a consequenca of): Chronic Obstructive Pulmonary Disease

b. ~~Non-Q wave MI~~ One week

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or es a consequenca of): Mycocardial Infarction

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hyper cholosterolemia

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☐Yas 2☑No

24b. Were autopsy tindings available prior to completion of causa of death? 1☐Yes 2☑No

25. Was case referred to medical examiner? 1☐Yas 2☑No

26. Piece of Deeth (Check only one): Hospital: 1☑Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Menner of Death: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, deeth occurred at tha time, dete end place, end due to the cause(s) and manner as stated. 2☐Medical Examiner: On tha basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Seyed A. Jalali

29c. License number: AS2441614A56

29d. Dete signad (Month, Day, Year): Jan, 12, 2001

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): 3001 South Hanover Baltimore, MD 21225

State Registrar

31. Data filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signatura: B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

01-0435-510
jhm
PHYLLIS D
DAWSON

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02988

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PHYLLIS D. DAWSON
2. Date of Death Month JANUARY Day 26, Year 2001
3. Time of Death: 01:06 AM
4a. Facility Name (If not institution, give street and number): ST. AGNES HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-70-5387
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 42 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 01-25-1458
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 3329 BRIGHTON STREET
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☑Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12TH GRADE
College (1-4or 5+): 2 YRS
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MANAGER
16b. Kind of Business/Industry: RETAIL

17. Father's Name (First, Middle, Last): WILLIAM HODGE SR.
18. Mother's Name (First, Middle, Maiden Surname): NETTIE FAYLEON

19a. Informant's Name/Relationship (Type, Print): GLEN DAWSON / HUSBAND
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3329 BRIGHTON ST., BALTO. MD. 21216

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY
Date: 1-31-01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Asthma
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one) Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Dennis J Chute
29c. License number: OCME
29d. Date signed (Month, Day, Year): JANUARY 26, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ Jennifer A. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020 — To Be Completed by Funeral Director — permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, — Medical Certification: To Be Completed by Physician/Medical Examiner — To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02989

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET A. DATES

2. Date of Death — Month: 01 Day: 26 Year: 2001

3. Time of Death: 0415

4a. Facility Name *(If not institution, give street and number)*: LEVINDALE NURSING HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 212-42-9130

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 96 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04-08-1904

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☑ Yes 2☐ No

10e. Street and Number: 140 POPULAR GROVE STREET

10f. Zip Code: 21216

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☑ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☑ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12TH GRADE — College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOME MAKER

16b. Kind of Business/Industry: DOMESTIC

17. Father's Name *(First, Middle, Last)*: DANIEL CONAWAY

18. Mother's Name *(First, Middle, Maiden Surname)*: SARAH WIGGINS

19a. Informant's Name/Relationship *(Type, Print)*: SHIRLEY CONAWAY / NIECE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2330 MOSHER ST. BALTO. MD. 21216

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARBUTUS MEMORIAL PARK — Date: 1-31-01

20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene

22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ovarian cancer — months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?: 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Was case referred to medical examiner?: 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work?: 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Susan M. Levy MD

29c. License number: D33943

29d. Date signed *(Month, Day, Year)*: 1/26/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Susan M Levy MD Levindale 2434 W Belvedere

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 05 2001

32. Registrar's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02990

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ZENNIE E. EVANS

2. Date of Death (Month, Day, Year): January 31, 2001

3. Time of Death: 9:20 pm

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: 213-18-6042

8. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): JAN. 24, 1915

9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD

10b. County: NA

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2217 EUTAW PLACE

10f. Zip Code: 21217

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRIYAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CATERING

16b. Kind of Business/Industry: FOOD SERVICE

17. Father's Name (First, Middle, Last): THOMAS CUTLER

18. Mother's Name (First, Middle, Maiden Surname): ZENNIE E. YOUNG

19a. Informant's Name/Relationship (Type, Print): SYLVIA E. HILL (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3208 GREENMEADE ROAD BALTIMORE, MD 21244

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): KING MEMORIAL PARK

Date: 2/7/01

20c. Location - City or Town, State: RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA
638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Ruptured Abdominal Aortic Aneurysm

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Willie Williams M.D.

29c. License number: P 14585

29d. Date signed (Month, Day, Year): 1/31/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Willie Williams, M.D. c/o Maryland General Hospital

State Registrar

31. Date Filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Zennie Evans.

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 2001 02991

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Karen Edwards

2. Date of Death: Month: February Dey: 3 Year: 01

3. Time of Death: 1530

4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death: NA

Funeral Director

5. Social Security Number: unk

6. Sex: 1☐ M 2☑ F

7. Age (In yrs. last birthday): 40 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): MAY 10, 1960

9. Birthplace (State or Foreign Country): BERMUDA

Usual Residence of Decedent

10a. State: BERMUDA

10b. County: NA

10c. City, Town or Location: PEMBROKE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: WEST PEMBROKE PARK

10f. Zip Code: HM!!

10g. Citizen of What Country: BERMUDA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: AFRICAN AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TEACHER

16b. Kind of Business/Industry: SCHOOL

17. Father's Name (First, Middle, Last): LEROY PENISTON

18. Mother's Name (First, Middle, Maiden Surname): EILEEN EDWARDS

19a. Informant's Name/Relationship (Type, Print): ZINA EDWARDS (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): LILY PARK, ST. GEORGES BERMUDA GE04

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ST. JOHN'S CEMETERY

Date: 2/10/01

20c. Location - City or Town, State: PEMBROKE, BERMUDA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Intracranial Hemorrhage	1 day
Due to (or as a consequence of):	b. HTN	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Renal Failure	3 years
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: 20897

29d. Date signed (Month, Dey, Year): February 5 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Chris Gibbons 600 N. Wolfe ST Baltimore MD 21287

State Registrar

31. Date filed (Month, Dey, Year): FEB 05 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02992

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JEAN FEDERICO
2. Date of Death (Month, Day, Year): February 2, 2001
3. Time of Death: 1:25 AM
4a. Facility Name (If not institution, give street and number): Johns Hopkins Bayview Geriatric Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-52-3118
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/15/1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5200 Eastern Avenue
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): John Sokolowski
18. Mother's Name (First, Middle, Maiden Surname): Camille Prejs

19a. Informant's Name/Relationship (Type, Print): Edward Sokolowski / Brother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1926 Bayberry Road Edgewood, Maryland 21040

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Dulaney Valley Cemetery
Date: 2/5/01
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Homes, P.A. 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. DEMENTIA — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

History of Left Breast Cancer

History of Schizophrenia

History of Bowel Adhesions

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas Finucane
29c. License number: D24334
29d. Date signed (Month, Day, Year): Feb 2, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS FINUCANE J.H. Bayview Hosp

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: Geneva G. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02993

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Helen J. Hilton
2. Date of Death (Month, Day, Year): February 2, 2001
3. Time of Death: 10:00pm
4a. Facility Name *(If not institution, give street and number)*: 3338 Clarenell Road
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 220-14-1784
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 5, 1926
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. Stete: MD
10b. County: N/A
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1456 Stevenson Street
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wea Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, apecify Cuban, Mexican, Puerto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent'a Educetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 9 — College (1-4or 5+): 0
16a. Decedent's Uaual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Joseph J. Bernwinkler
18. Mother's Neme *(First, Middle, Maiden Surname)*: Margaret J. Hyland

19a. tnforment'a Name/Reletionship *(Type, Print)*: Johann Mossman / Daughter
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 230 3rd Avenue, Baltimore Maryland 21227

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery — Dete: February 6, 2001
20c. Location - City or Town, State: Baltimore Maryland

21. Signature of Funeral Service Licensee: Victor P. Doda, Jr. ▶ [signature]
22. Name and Address of Facility: Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore Maryland 21230

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on eech tine. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Intestinal obstruction — one month
Due to (or as e consequence of):
b. Rectal Cancer — 2 years

Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or ea e consequence of):
c.
Due to (or as e consequence of):
d.

Part It. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Diabetes Mellitus
atherosclevotic Cardiovasular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ tnpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Sons House

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, atreet, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: ▶ Afroze Mulneer MD
29c. License number: D45105
29d. Date signed *(Month, Day, Year)*: February 5, 2001

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print): AFROZE MULNEER 401 E. Fort ave Baltimore MD 21230

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 05 2001
32. Registrer's Signature: ▶ [signature]

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

01-0510-510
crn
Timothy Henderson
amend item 23a,27,28a-f per me G792 2/13/01 yf

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar

Certificate of Death

Reg. No. 2001 02994

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Timothy	Henderson	January 30, 2001	11:55 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Johns Hopkins Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
218-88-1610	1 X M 2 F	36 Yrs.			11-22-64	MD

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	NA	Baltimore	X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2901 Matthew Street	21213	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 X No If Yes, Give Year or Dates:	1 Yes X 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
9th Grade	NA	Driver	Pimilco Race Track

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Clyde Oglesby	Madeline Henderson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Madeline Sparks	2901 Matthew Street Baltimore, Maryland 21213

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
X Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)	Arbutus Mem. Pk.	Cem. 02-07-01	Arbutus, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Gladys Ward	Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. COCAINE AND NARCOTIC INTOXICATION	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one) Inspection
1 X Yes 2 No	Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 X Could not be determined	found 1/30/01	unknown M	1 Yes 2 X No	unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
residence	234 Douglas Court Baltimore, Md

29a. Certifier (Check only one) 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Theodore M. King M.D.	O.C.M.E.	January 31, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 05 2001	G Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification; To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02995

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha May Husen

2. Date of Death: Month Feb Day 1 Year 2001

3. Time of Death: 9:11AM

4a. Facility Name (If not institution, give street and number): Good Samaritan Hospital

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 214-74-6241

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 96 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 20, 1904

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6225 York Road Apt. E203

10f. Zip Code: 21212

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4th grade | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own home

17. Father's Name (First, Middle, Last): John Thomas Powell

18. Mother's Name (First, Middle, Maiden Surname): Charlotte Ellen Harding

19a. Informant's Name/Relationship (Type, Print): Goldie Husen /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6225 York Road Apt. E203 Baltimore, maryland 21212

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Stevenson AME Church Cem | Date: 2-7-2001

20c. Location - City or Town, State: Sparks, Maryland

21. Signature of Funeral Service Licensee: ▶ Leroy Harris

22. Name and Address of Facility: Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, maryland 21212

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Myocardial Infarction — 20min

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Hypertension
Vascular Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28i. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Edward Seidel MD

29c. License number: D38956

29d. Date signed (Month, Day, Year): Feb 1, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Seidel MD 5601 Loch Raven Blvd. Baltimore MD 21239

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001

32. Registrar's Signature: ▶ Geneva G. Banks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02996

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Beacher Johnson
2. Date of Death (Month, Day, Year): February 03, 2001
3. Time of Death: 5:02am

4a. Facility Name (If not institution, give street and number): Joseph Ritchie Hospice
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 215-90-7829
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 35 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 19, 1965
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD.
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5215 Ready Avenue
10f. Zip Code: 21212
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Maintenance Engineer
16b. Kind of Business/Industry: Furniture

17. Father's Name (First, Middle, Last): Douglas M. Johnson
18. Mother's Name (First, Middle, Maiden Surname): Helen Terry

19a. Informent's Name/Relationship (Type, Print): Helen Johnson (Sister)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1838 East 29th Street Baltimore, Maryland 21218

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Metro Crematory
Date: 2/05/01
20c. Location - City or Town, State: Catonsville, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Dennis B. Caple F.H. P.A. 4601 York Road Baltimore, MD. 21212

To Be Completed by Funeral Director

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Albert Johnson February 3, 2001 5:02 am

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. AIDS — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or es a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☑ Other (Specify) Hospice

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] Diana H. Griffiths MD
29c. License number: D0019419
29d. Date signed (Month, Day, Year): February 3, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Diana H. Griffiths M.D. C/o St. Agnes Hospital 900 Caton Ave Balto, MD 21229

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02997

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EUGENE JOHNSON
2. Date of Death: Month JANUARY Day 31 Year 2001
3. Time of Death: 2:00 AM
4a. Facility Name (If not institution, give street and number): Maryland General Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: 231 38 4228
6. Sex: 1 ☑ M 2 ☐ F
7. Age (In yrs. last birthday): 61 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN. 18, 1940
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: Baltimore City
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 4514 FAIRFAX RD
10f. Zip Code: 21216
10g. Citizen of What Country? USA

11. Meritel Status: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondery (0-12): 12
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAREHOUSE SUPERVISOR
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): LOGAN JONES
18. Mother's Name (First, Middle, Maidan Surnama): BERTHA JOHNSON

19a. Informant's Name/Relationship (Type, Print): VIRGINIA JOHNSON, WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4514 FAIRFAX RD. BALTIMORE, MD 21216

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cramatory or other place): GARRISON FOREST VET. Date: 2/6/01
20c. Location - City or Town, State: OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee: [signature] MD1015
22. Name and Address of Facility: VAUGHN C. GREENE F.S. 5151 BALTO. NAT'L PIKE BALTO., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEPSIS
Due to (or as a consequence of):
b. CIRCULATORY FAILURE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signeture end title of certifier: [signature]
29c. License number: 89371
29d. Date signed (Month, Day, Year): JANUARY 31, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GOVIND MULCHANDANI C/O MARYLAND GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature] G. Hooks

DHMH 16 Rev 6/95

ORIGINAL

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Johnson, Eugene

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 02998

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SANDRA JEFFERS
2. Date of Death (Month, Day, Year): January 30 2001
3. Time of Death: 2:16 am
4a. Facility Name (If not institution, give street and number): 6000 SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 217 56 8882
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APRIL 23, 1951
9. Birthplace (State or Foreign Country): Balto, MD

Usual Residence of Decedent

10a. State: MARYLAND
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 1021 RICHNOR AVENUE
10f. Zip Code: 21212
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☑ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLAIMS EXAMINER
16b. Kind of Business/Industry: HEALTHCARE

17. Father's Name (First, Middle, Last): JAMES FARBES
18. Mother's Name (First, Middle, Maiden Surname): IRENE HILL

19a. Informant's Name/Relationship (Type, Print): DARNELL JEFFERS, SPOUSE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1021 RICHNOR AVE. BALTO., MD 21212

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY
Date: 2/8/01
20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee: [signature] M0015
22. Name and Address of Facility: VAUGHN C. GREENE F.S. 5151 BALTO.-NAT'L PIKE BALTO., MD 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Intracerebral Hemorrhage
Due to (or as a consequence of):
b. CVA
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
-Non small Cells LUNG CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] MD
29c. License number: P13c153
29d. Date signed (Month, Day, Year): January 30 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GONZALO GIANECLA MD. 5601 Loch Raven Blvd. BALTIMORE

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: [signature] B. Sparks

ORIGINAL

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 2001 02999

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILLIE ANN JACOBS
2. Date of Death (Month, Day, Year): 01-28-2001
3. Time of Death: 6:53 P M
4a. Facility Name (If not institution, give street and number): 613 ARCHER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-26-9015
6. Sex: 1☐M 2☑F
7. Age (In yrs. last birthday): 89 Yrs.
If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07-12-1912
9. Birthplace (State or Foreign Country): VA

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 613 ARCHER
10f. Zip Code: 21230
10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☐Married 3☑Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☑No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOME MAKER
18b. Kind of Business/Industry: DOMESTIC

17. Father's Name (First, Middle, Last): JAMES COLBERT
18. Mother's Name (First, Middle, Maiden Surname): SARAH SPRIDLEY

19a. Informant's Name/Relationship (Type, Print): LENORA DAILEY / GD. DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 SPARROWHILL CT., BALTO. MD. 21228

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS CEMETERY; Date: 2-01-01
20c. Location - City or Town, State: BALTO. MD

21. Signature of Funeral Service Licensee: ▶ Vaughn C Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): a. Dementia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Approximate Interval Between Onset and Death: 6 months

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐Yes 2☑No 9☐Unknown
23c. If yes, outcome of pregnancy: 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy 4☐Pregnant at time of death 5☐Other (specify) 9☐Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: Hypertension

23e. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☑No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☑No

28. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Death: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D.
29c. License number: D26307
29d. Date signed (Month, Day, Year): 1/29/01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RANI S. KARIPINENI 4000 ANNAPOLIS RD BALTIMORE, MD 21227

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶

Medical Certification; To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 28e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

RKD

01-0423-510

EARL JACKSON amend item 23a,27,28a-f per me 3792 2/13/01 yl
AMEND#11 PER F.H. G792 2-12-2001 JAB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2001 03000

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EARL JACKSON JR.
2. Date of Death (Month, Day, Year): JANUARY 25, 2001
3. Time of Death: 2:02P.M.
4a. Facility Name (If not institution, give street and number): GOOD SAMARITAN HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 229-40-0681
6. Sex: 1☑M 2☐F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 06-03-1946
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☑Yes 2☐No
10e. Street and Number: 1339 PENRIDGE ROAD
10f. Zip Code: 21215
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☑Yes 2☐No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☑No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ARMY OFFICER
16b. Kind of Business/Industry: ARMED FORCES

17. Father's Name (First, Middle, Last): EARL JACKSON, SR.
18. Mother's Name (First, Middle, Maiden Surname): ROSSETTA BAILY

19a. Informant's Name/Relationship (Type, Print): EARL JACKSON, III / SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6634 EBERLE DR., BALTO. MD. 21215

20a. Method of Disposition: 1☑Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARLINGTON CEMETERY
Date: 2-7-01
20c. Location - City or Town, State: ARLINGTON, VA

21. Signature of Funeral Service Licensee: ▶ Vaughn C. Greene
22. Name and Address of Facility: VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD. 21229

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. COCAINE INTOXICATION AND SMOKE INHALATION
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings available prior to completion of cause of death? 1☑Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☒Could not be determined
28a. Date of Injury (Month, Day, Year): found 1/25/01
28b. Time of Injury: found 1:11 P M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): residence
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1339 Pentridge Road Baltimore, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Theodore M. King
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): JANUARY 26, 2001
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 05 2001
32. Registrar's Signature: ▶ Lenora B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

DHMH 16 Rev 6/95

ORIGINAL